S. HRG. 107–791

OVERSIGHT HEARING ON THE INTEGRATION OF VETERANS INTEGRATED SERVICE NETWORKS 13 AND 14

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

MAY 13, 2002

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

83–280 PDF WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MAY 13, 2002

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WITNESSES

OVERSIGHT HEARING ON THE INTEGRATION OF VETERANS INTEGRATED SERVICE NETWORKS 13 AND 14

MONDAY, MAY 13, 2002

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:12 a.m., the Alumni Center Building, University of Nebraska at Omaha, 6500 Dodge Street, Omaha, NE, Hon. E. Ben Nelson presiding.

Present: Senator Nelson.

Senator NELSON. [Raps gavel.] I've always seen Chairman Rockefeller do that and I always had the desire to do that and now I have just done it and this morning I would like to thank you all for being here and call to order this field hearing of the Veterans' Affairs Committee of the U.S. Senate. I would like to thank everyone for your attendance here today and for the opportunity to learn and to discuss more about the services our veterans have earned and receive here in Nebraska.

For the veterans in the room, I want to give you my personal thanks and thanks on behalf of everyone for your service and your sacrifice. Your service and sacrifice give us the freedom to express our opinions as we will do here today.

I would also like to thank my friend Secretary Principi for his attendance, and his staff as well, for taking the time out of what is obviously a very busy schedule for being here today to listen to Nebraska's veterans. Special word to Jim Cada, my classmate from law school; he'll be testifying here with the second panel, and I want to thank Jim for everything that he has done to help make this possible today as well.

As a matter of housekeeping items, we'll hear testimony from 14 witnesses on three panels today. That's an aggressive effort. And although we couldn't accommodate everyone who wanted to testify, we have tried to present a broad spectrum of veterans experts and veterans affairs. I apologize to those that we were unable to accommodate. We've got a signing specialist here today, if I could see a show of hands today for those who may need the services of a sign language interpreter? Is there anyone who has a special challenge that would need these services because she could come closer? I guess we're in good shape, and we appreciate very much you being here today.

If you have cell phones with you, could you please switch them off ring to vibrate, so that we don't have any unnecessary interrup-

tions as a result. I notice that if one of those vibrates or one of those rings these days, everybody jumps for theirs, they feel guilty, thinking maybe it's theirs. I'm fortunate I haven't had mine ring in a hearing or anything like that, but I have seen it happen to various other people. If you would, please put them in the vibrator or off position.

Today we are holding a field hearing on the issues and concerns relating to the integration of VISN's 13 and 14, and for the benefit of us all, I want to review how it is that we came to the decision to call for a field hearing.

On December 11rd, I received a letter from Secretary Principi stating that he had asked for the Veterans Health Administration to conduct a review of the possible merger of VISN's 13 and 14 and I also received a draft copy of the Administration findings.

Then on January 23th, I received another letter from the Secretary stating that he had approved the integration and that it should be conducted as rapidly as possible.

On the same day a press release was issued by the Department of Veterans Affairs announcing the decision to integrate the VISN's and that Dr. Petzel, who is here with us today, was selected to be the interim network director of the proposed VISN 23. In addition to the letter, Undersecretary Laura Miller conducted a staff briefing in DC about the consolidation.

On January 24th, I sent a letter to the Secretary and Dr. Petzel addressing my concerns with merging both VISN's. At the same time my colleague and my friend, Congressman Bereuter, was also directing a letter raising concerns about the integration. I didn't understand why speed was necessary in the process before we could fully understand the ramifications of integration and why there wasn't time to begin dialog on the issue. There are over 450,000 veterans in VISN 14 with a vested interest. We were not informed of how the merger would affect their earned care, how it would affect the quality and quantity of their care, or if there would be any effect at all. We also felt that elected representatives weren't given the time or evidence in order to adequately address these concerns.

So on February 14th, we held a Veterans' Affairs hearing in the U.S. Senate. I thanked the Secretary for his help on the Grand Island Veterans Nursing Home facility where he had been very responsive. I invited him to Nebraska for a field hearing to address Nebraska's concerns about VISN integration. The Secretary at the time said he would be honored to come, and he kept his word.

On March 25th, the Secretary assured me that the services provided to Nebraska's veterans would not be affected by the merger.

This brings us up to date, for the record, of what happened and why we are all here today. It brings us up to date on the issue, but unfortunately there's still lingering questions and concerns about how care might be affected and if the decision to integrate is warranted.

There have been at least two other studies prior to the most recent one in late 2001 on whether or not VISN's 13 and 14 should be integrated. Both concluded that there was not a substantial cost savings to warrant the merger and now we're under the impression that somewhere between $650,000 and $1 million may be saved.

Obviously, there's no guarantee that there will be a savings in this situation, or at least, there was no guarantee in the study. This adds up to about 1 percent of the VISN's 13 and 14 combined budget, which leaves speculation about what VISN 23's budget will actually be.

It appears that there are many sound arguments for not integrating and as far as I can tell maybe three reasons to integrate; cost savings, consolidated leadership, and consolidating two large geographic but lightly populated areas.

Last year VISN 14 had a patient satisfaction rate of 64 percent, which is 2 percentage points above the national average, yet it failed to meet the 45-day fully successful standard in 3 out of 6 clinics. This leads me to believe that Nebraska veterans are patient and pleased with their care, so I am deeply concerned when I get letters from veterans in Nebraska that say the veteran health care system in Nebraska may not be as it should be. So I hope that these rates climb this year because the quality of care and the time it takes a veteran to receive care will be the true test of whether this merger is the right decision.

VISN 23 would encompass 429 counties and 12 different States serving over 1 million veterans. The decision to integrate has, unfortunately, already been made. I know that Secretary Principi has the best interests of veterans at heart, but the process in making the decision, in my opinion, should have included something similar to what we are doing today. But better late than never, so we are here to help veterans, and their representatives, become better informed about their care givers on how and why this process is going to proceed as well as soliciting opinions on if it is necessary. The good of our veterans should always be our goal as public servants.

In order to allow everyone to voice their opinions to gain more information, opening statements will be limited to 5 minutes and we have brought one of our verbal traffic lights here from DC which has always mesmerized me. When the red light is on, you've exhausted your 5 minutes.

[The prepared statement of Senator Nelson follows:]

PREPARED STATEMENT OF HON. E. BENJAMIN NELSON, U.S. SENATOR FROM NEBRASKA

Good Morning. I would like to thank all of you for appearing here today to discuss the services our veterans have earned and receive here in Nebraska, For the veterans in the room, it is thanks to your service and sacrifice that we have the freedom to express our opinions, as we will do here today. I would also like to thank Secretary Principi and his staff for taking the time out of their busy schedule to visit with Nebraska's veterans. Jim Cada is also here today, he will be testifying here with the second panel, and I want to thank you for everything you have done to make this hearing possible.

Today we hold a field hearing on the issues and concerns relating to the integration of VISNS 13 and 14. For the benefit of all of us, I want to review how it is that we came to the decision to call for a field hearing.

On December 11th, I received a letter from Secretary Principi stating that he had asked the Veteran's Health Administration to conduct a review of the possible merger of VISNs 13 and 14. I also received a draft copy of the administrations findings.

On January 23rd, I received another letter from the Secretary stating that he had approved the integration and that it be conducted "as rapidly as possible."

On the same day a press release was issued by the Department of Veterans Affairs announcing the decision to integrate the VISNs and that Dr. Petzel, who is here with us today, was selected to be the interim network director of the proposed

VISN 23. In addition to the letter, Undersecretary Laura Miller conducted a staff briefing in D.C. about the consolidation.

On January 24th, I sent a letter to the Secretary and Dr. Petzel addressing my concerns with merging both VISNs, I did not feel and did not understand why speed was essential in the process before we could fully understand the ramifications of integration. And why there was not time to begin dialogue on the issue. There are over 450,000 veterans in VISN 14 with a vested interest that were not informed of how the merger would affect their earned care. Elected representatives were not given enough time, discussion, nor evidence in order to adequately address their concerns either.

On 14 February, we held a Veterans' Affairs hearing in the United States Senate where I thanked the Secretary for his help on the Grand Island Nebraska Veterans' Nursing Home facility and invited him to Nebraska for a field hearing to address Nebraska's concerns about VISN integration.

On 25 March, the Secretary assured me the merger would not affect veterans' services in Nebraska.

This brings us up to date on this issue but unfortunately there still exist many lingering concerns about how care will be affected and if the decision to integrate is warranted.

There have been at least two other studies prior to the most recent in late 2001 on whether or not VISN's 13 and 14 should be integrated. Both concluded that there was not a substantial cost savings to warrant the merger. Now we are under the impression that somewhere between $650,000 and $1,000,000 may be saved but there is no guarantee of a savings in this study either. This adds up to about 1 percent of the VISN 13 and 14 combined budget. Which leaves speculation about what VISN 23's budget will be.

It appears that there am many sound arguments for not integrating and as far as I can tell maybe three reasons to integrate; cost savings, consolidated leadership, and consolidating two large geographical but lightly populated areas.

Last year VISN 14 had a patient satisfaction rate of 64%, which is 2 points above the national average, yet it failed to meet the 45-day fully successful standard in 3 out of 6 clinics. This leads me to believe that Nebraska veterans are patient and pleased with their care so I am deeply concerned when I get letters from veterans that say the veteran health care system in Nebraska is not as it should be. I hope those rates climb this year, because the quality of care and the time it takes a veteran to receive care will be the true test of whether this merger is the right decision.

VISN 23 would encompass 429 counties and 12 different states serving over 1 million veterans. The decision to integrate has unfortunately already been made, and I know that Secretary Principi has the best interests of veterans at heart, but the process in making the decision should have included something similar to what we are doing today. Informing veterans, their care givers, and their representatives on how and why this process is going to proceed as well as soliciting opinions on if it is necessary and good for our veterans should always be our goal as public servants.

In order to allow everyone to voice their opinions and for us to be successful in gaining more information about today's subject of integration from different experts, opening statements will be limited to 5 minutes. We have brought one of our verbal traffic lights here from D.C. Obviously when the red light is on you have exhausted your five minutes.

Secretary Principi, again, welcome to Nebraska, and I look forward to hearing your comments.

Senator NELSON. Before we begin, I would ask my friend and colleague, Congressman Bereuter, if he would have an opening statement to make? We appreciate very much his being here today as well.

STATEMENT OF HON. DOUG BEREUTER, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. BEREUTER. Senator Nelson, I appreciate the fact that you are holding this hearing here and that you invited me to participate when I expressed my concerns similar to your own. I had a full day of meetings scheduled in Lincoln, but we have rearranged things. I won't be able to stay for much of the hearing, but I want to learn as much as I can in the brief time available and also to share some thoughts about this subject.

Secretary Principi, we very much appreciate your attendance here, you and your staff, all of the distinguished witnesses, veterans leaders and the people that support them and their families today. The subject, of course, is the proposed merger of VISN, V-I-S-N, Veterans Integrated Service Network. I happen to think that the primary problem underlying it however is the VERA program, which is Veterans Equitable Resource Allocation system which isn't equitable in my judgment and that's the basic problem we're having today in this part of the country. And so I wrote to Secretary Principi in January and I believe that's about the same timing of your expressed concern, Senator, and I do oppose the merger which was officially announced.

I think unfortunately the VA simply has not presented a strong case that the merger will improve the service for Nebraska's veterans or that it will result in addressing the ongoing funding shortfalls which have plagued both VISN's. Indeed, VISN's 13 and 14 have a combined shortfall of $92.7 million for fiscal year 2001, but a consultant's study not too long ago suggested that there is no cost effective efficiency resulting from the proposed merger. That's not too long ago that that statement was made. And, of course, the merger savings are said to be or projected to be somewhere between $1 and $6 million now. That's in contrast to what was said earlier.

Immediately upon receiving that information about the merger, I sent a letter to the Secretary to protest the merger. In the response which I received from the Secretary he stated that the merger in and of itself will not bring financial stability to the two VISN's, and I agree with that. Subsequently, I therefore must ask two questions: (1) Why does the VA plan to simply restructure the VISN system rather than find a long-term solution to the continuing financial shortfalls facing VA facilities in the midwest, especially the Northern Great Plains, and (2) what value does the merger add to the quality of service which veterans in our Heartland will receive?

I would note that I believe the current VISN structure is not the primary reason for the financial woes that VISN 14 and VISN 13 face and which VISN 23, that's a new one, would now face. Indeed, I have been a long-term outspoken opponent of the badly misnamed Veterans Equitable Resource Allocation system, or VERA. Through VERA, the VA distributes its health care budget on the basis of a per capita veterans usage of facilities, not basic health care facility needs or geographic considerations. For sparsely populated States such as Nebraska, this is simply unfair to veterans who are entitled to VA health benefits and who are forced to drive many miles to receive this care.

In a letter to the Secretary that I sent, I would like to quote from it. When the Clinton administration constructed these arbitrary regional divisions and subsequently instituted the VERA system, I also strongly protested that these policies would negatively impact health care services to veterans in rural areas. Allocating veterans health care funds on a veteran per capital basis is unbelievably discriminatory for sparsely settled States like Nebraska. I and other representatives in Congress from such States have tried unsuccessfully to alter this formula since it was announced. Every veteran,

no matter where he or she lives, deserves equal access to VA medical services, equal to those living in sun-belt States. As we see this migration of veterans to the southland, we're left here with less and less veterans and yet we have to provide the full degree of veterans care that the Nation has promised its veterans in these settled parts of the country. So we voted on this issue on three or four occasions on the House floor, but it runs into a strictly geographic kind of vote and the veterans in New York or New England also have some of the same concerns, but it is particularly acute for the people who live in the Northern Great Plains. So I think that's the basic problem that VISN's has today. You cannot simply provide adequate health care to the veterans of the Northern Great Plains on a per capital funding basis. That is just too simplistic. It is not the way that we should do things in this country.

So you can have a merger between VISN 13 and 14, but that just is a little attempt to adjust numbers and to write a few efficiencies if that and the basic problem is the VERA system, it needs to be abandoned. It should have been abandoned by the Clinton administration. It should be abandoned by the Bush administration and something more equitable determined. So those are my concerns. I feel very strongly about that because my veterans are not receiving the same health care opportunities that veterans in other parts of the country receive and that is because of a discriminatory VERA system. So we can look at VISN today and we know that's the primary focus, but the basic problem is the VERA program.

Senator Nelson, thank you very much for giving me a chance for me to speak and to listen on this subject. I think that you do us a great service by giving this careful scrutiny today and I thank you for your initiative and I would be pleased now to hear from the Secretary and the other witnesses.

[The prepared statement of Mr. Bereuter follows:]

PREPARED STATEMENT OF HON. DOUG BEREUTER, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. Chairman, I would like to express my appreciation to the Senate Veterans' Affairs Committee for convening this field hearing in Nebraska. Additionally, I would like to commend my colleague in the Nebraska Congressional Delegation (Senator Ben Nelson) for his efforts to highlight the issue before us today. Indeed, the merger of Veterans Integrated Service Network (VISN) 14, which includes Nebraska, Iowa, and western Illinois, with VISN 13, which includes Minnesota, North Dakota, and South Dakota, is a topic which certainly deserves greater examination by Congress and more detailed explanation on the part of the Veterans Administration (VA).

I strongly oppose the merger which was officially announced by Department of Veterans Affairs (VA) Secretary Anthony Principi on January 23, 2002. Unfortunately, the VA simply has not presented a strong case that the merger will improve care for Nebraska's veterans or that it will result in addressing the ongoing funding shortfalls which have plagued both VISNs. Indeed, VISNs 13 and 14 have a combined shortfall of $92.7 million for FY2001.

Immediately upon receiving information about the merger, I sent a letter to VA Secretary Anthony J. Principi to protest the merger. In the response, which I received from the VA, Secretary Principi stated that "the merger, in and of itself, will not bring financial stability to the two VISNs." Subsequently, I must ask two questions? (1) why does the VA plan to simply restructure the VISN system rather than find a long-term solution to the continued financial shortfalls facing VA facilities in the Midwest, and (2) what value does the merger add to the quality of service which veterans in our heartland will receive?

I would note that I believe that the current VISN structure is not solely to blame for the financial woes which VISN 14 and VISN 13 faced and which VISN 23 must

now face. Indeed, I have been a frequent and outspoken opponent of the Veterans Equitable Resource Allocation (VERA) system. Through VERA, the VA distributes its health care budget on the basis of a per capita veterans usage of facilities, not basic health care facilities needs or geographic considerations. For sparsely populated states such as Nebraska, this is simply unfair to veterans who are entitled to VA health benefits and who are forced to drive many miles to receive care.

During the House Floor debate on the VA, Housing and Urban Development (HUD), and Independent Agencies appropriations bill for FY2002 (H.R. 2620), I spoke in favor of an amendment offered by Representative Rodney P. Frelinghuysen (R-NJ) which would have prohibited the use of funds in the bill for implementing the VERA system. Unfortunately, and to my dismay, the Frelinghuysen amendment was withdrawn, and, therefore, the House did not vote on it. Such amendments have been defeated during the past several years, and I suspect Mr. Frelinghuysen wanted to avoid still another defeat on a recorded vote.

Mr. Chairman, the health care needs of our military veterans must be met to the fullest extent possible. Veterans fought to protect our freedom and way of life. As they served our nation in a time of need, the Federal Government must remember them in their time of need. The people of the U.S. owe our veterans a great deal and should keep the promises made to them. I look forward to hearing Secretary Principi's responses to the questions I have raised and any other insights he might provide on the future of the misbegotten VERA system now in effect.

I am committed to ensuring that Nebraska's veterans receive the benefits they deserve—benefits they have been promised and which the American people support. The VERA system stands in the way of meeting that commitment to the veterans of Nebraska and other sparsely settled states of the Northern Great Plains and the northern states in the Rocky Mountain region of our country.

Thank you.

Senator NELSON. Thank you, Congressman Bereuter.

Our first panel is a very distinguished panel. First of all, we have Secretary Anthony J. Principi, who is the Secretary of the U.S. Department of Veterans Affairs; Dr. Robert A. Petzel, the Acting Director, Veterans Integrated Service Network No. 23; Gary Nugent, is the Chief Executive Officer, VA Nebraska-Western Iowa Health Care System; and John Hilgert, former State senator, Director of the Nebraska Department of Veteran Affairs.

Once again, Secretary Principi, it's a real pleasure to have you in Nebraska and we are very anxious to learn from you and help you learn from us.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. PRINCIPI. Thank you, Mr. Chairman, Mr. Bereuter. It is certainly a pleasure to be with you. I thank you so much for your kind invitation to visit Nebraska to attend this field hearing. I'm pleased to be accompanied by Dr. Petzel, our acting Network Director, Network VISN 23 and Mr. Gary Nugent, the Director here in Omaha and I'm certainly pleased to be with Mr. John Hilgert.

I'm also very honored to be in the company of so many distinguished veteran leaders, members of veteran service organizations, and my fellow VA employees who are here this morning for this hearing.

I thank you for the opportunity to discuss the merger of VISN 13 and 14 into VISN 23, the meaning of that merger and perhaps to address some of the other issues that you highlighted this morning, Mr. Bereuter, and Mr. Chairman as well.

Let me begin by bringing a national perspective to this regional issue. The Department of Veterans Affairs faces extraordinary challenges in providing health care today. We are reaching crisis

levels, I'm afraid to say, and I want to talk a little bit about the historical perspective for it.

In the mid-1990's a couple of very important decisions were made that profoundly impacted and changed the face of the VA today. The first I think was a very, very important decision, and that was to transition the VA from a hospital centric health care system to a more primary patient focused health care system. The result of that is that today VA has some 800 outpatient clinics which are much closer to veterans homes. Whereas in the past, of course, we had very, very few, if any, community based outpatient clinics and that made it much more difficult for veterans to access the VA health care system.

Also about the same time, around 1998, the decision was made to go to enrollment so that any veteran whether they're service-connected disabled by virtue of their military service, poor, nonservice connected higher income, anyone can come to the VA. Prior to that time, of course, the VA was considered to be a health care system for men and women who were disabled by virtue of their military service and/or poor. It was a safety net for poor veterans. But with that change to open enrollment, any of the 25 million veterans could come to the VA health care system.

Those changes were premised on a couple of things happening. One was that we would have Medicare subvention. The VA would be able to tap into the Medicare trust fund because a large percentage of our veterans are Medicare eligible. They contribute to the trust fund. That never happened. Perhaps there were a lot of reasons for it, and I certainly don't blame the administration back then or the Congress, Medicare subvention just never was realized.

Another factor was that the VA would do much better in medical care cost recovery. We have the authority to bill the insurance company for nonservice connected health care. Congress gave us that authority back in 1998, to allow those dollars to stay with the VA, the networks, the medical centers where those dollars were collected. Our medical care cost recovery program didn't reach the levels that everyone anticipated back then, and, of course, appropriations—we're a discretionary funded health care system. We are not an entitlement program. Not one veteran under law, is entitled, so we have to rely upon annual appropriations, and Congress has been very, very generous with us. But the fact remains that as a result of opening all of the outpatient clinics, and open enrollment, veterans have come to us in significant numbers. Of course, we have had a lot of Medicare HMO's close down around the country. We have had fluctuations in the economy where veterans have lost their jobs and lost their health care coverage and have come to us. So as a result of these changes, we now have over 6 million veterans enrolled in the VA health care system. We have a million additional veterans who have used the system who never used it before. The growth in Priority 7's since 1996 has been dramatic. In 1996 they were 3 percent of VA's workload; today they comprise 33 percent and we expect that Priority 7's will be almost 50 percent by the end of this decade. They have grown 500 percent since 1996, and the growth this year alone is 50 percent higher than it was last year.

So the fact is, we have many veterans who are looking to the VA, and, of course, VA's quality is much better. This is not my father's VA. The VA health care system today is a truly fine, high quality health care system. Our Nation should be very, very proud of the health care system we have. But with the increasing number of veterans who are turning to us combined with the rising cost of health care, our pharmaceutical budget is now $3.1 billion. It has grown from $750 million to $3.1 billion and that's just for ingredients only. That does not include the cost of managing this program, which is about $600 million additional. You can see some of the challenges facing us. So we have had to make some hard decisions if we are going to continue to meet the ever growing increases on a finite budget.

Our budget requests for fiscal year 2003, I am very, very proud to say, is the largest increase ever requested by a President, whether Republican or Democrat. It is $6.1 billion more than 2002, about 7 percent for discretionary spending health care, when most agencies of Government are being limited to 2 percent. I am grateful to the Congress. I thank you for your leadership, Mr. Chairman, Mr. Bereuter, Senator Hagel and Congressman Osborne and for your tremendous support of VA in trying to get us additional resources. But I think we all know that unless we have something like Medicare subvention or increased appropriations, it is going to be difficult to meet the expanding need of health care.

So what we're trying to do, what I am trying to do as head of the VA, an agency that I am very, very honored and humble to lead, is the following: improve our procurement practices so that the dollars we save can be put back into health care, by reshaping our legacy infrastructure to meet the needs of 21st century veterans, not the century gone by, by increasing cooperation with the Department of Defense, health care system, through more sharing, more partnership, by improving our business practices.

I try to bring a business sense to what we do because we have a bottom line. It may not be dividends, but it certainly is more health care for veterans. Every dollar we save is a dollar we can use to expend the reach of health care, by increasing the effectiveness of our collections operations. You told us we can keep the dollars we collect from insurance companies. We need to do better because that is money that is being left on the table. VA is making intelligent use of the opportunities offered us by modern technology, telemedicine, so that in rural areas we can in fact reach some of those veterans that Congressman Bereuter talked about. VA is using telemedicine and radiology and psychiatry and continuing to look for ways to make our medical practices more cost effective without sacrificing quality. We have worked very, very hard. My predecessors have worked very, very hard to improve the VA's quality. I certainly do not want to see it diminished. Under no circumstances will I allow quality to be compromised.

Combining VISN 13 and 14 certainly as you both indicated will not solve all of our problems. Our challenges are much greater than the consolidation of these two networks. But I believe it is a step in the right direction. It is a step that will save us some dollars. Now, these are administrative management overhead dollars. These are not clinical dollars, and I really want to make sure that

I separate the two. By combining the networks, we are talking more in terms of administrative overhead as opposed to clinical practice.

I believe it is a step that will improve the quality of care for many veterans. It will allow us to better coordinate health care among veterans in a larger area of Nebraska, the Dakotas, Minnesota, and Iowa. It will affect veterans who previously used facilities in both networks.

I hope it will help us to reduce waiting times for appointments as we develop new strategies to make access to care more equitable. So those are primarily some of the reasons that we have undertaken this consolidation. I am told by Dr. Petzel that we are already saving money on pharmaceutical procurements through our widespread use of generic substitutes and laboratory contracts in the two now combined networks. We have already prepared a plan to expand psychiatric services in rural midwestern areas through the use of the telepsychiatry program. We will soon hire psychiatric regional care coordinators in both Nebraska and Iowa to enhance our services in this area and to ensure the project's success and we have already authorized funding for temporary new staff to renew our business procedures. This staff will prepare a plan so that we can increase our third-party collection from insurance companies.

But, Mr. Chairman, and Mr. Bereuter, let me be clear about one thing. None of the 28 employees of either network directly affected by this change provide direct patient care to veterans. VISN staff performs staff support work for the VISN Director and for the networks' facilities. Changing our network configuration will not curtail service at any VA facility that provides health care in Nebraska or anywhere else in either network because Networks 13 and 14 have a continuous boundary, have few facilities in metropolitan areas, and have large areas where rural health care is an issue. It is my hope that combining their management will enhance care while reducing costs. I believe that's a win/win situation for veterans and for the VA.

My time is well past the 5 minutes, Mr. Chairman, so at that point I will stop and be pleased to answer whatever questions you or Mr. Bereuter might have.

Thank you, sir.

[The prepared statement of Secretary Principi follows:]

PREPARED STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

I am pleased to appear before the Committee to discuss the merger of VISNs 13 and 14 into VISN 23 and what that merger means for the future of VA health care for all affected veterans.

On January 23, 2002, the Department of Veterans Affairs (VA) announced the merger of VISN 13 and 14 into new VISN 23. This merger has placed under one structure two health care networks that provided services to veterans in Iowa. Nebraska, Minnesota, South Dakota, North Dakota, and portions of western Illinois, western Wisconsin, and eastern Wyoming.

Combining these two Networks to improve health care delivery and access makes good sense. The facilities within the two VISNs maintain excellent Joint Commission for Accreditation of Health Care Organizations (JCAHO) scores, rank high in patient satisfaction, and are strong performers in quality measures. The change should have no effect on the facilities or their scores, beyond what is expected to be gained in administrative efficiencies. The two VISNs share many commonalities.

They are close geographically and both have few metropolitan areas and large areas where rural health care is an issue.

VISN 23 provides services throughout a large region that includes Iowa, Nebraska, Minnesota, South Dakota, North Dakota, western Illinois and western Wisconsin. The Network operates nine medical centers, thirty-five community-based outpatient clinics, four domiciliaries, and seven VA nursing homes. Nearly one million veterans reside within the Network service area, which represents 4.3 percent of the Nation's veteran population. In 2001, Network medical facilities served a total of 215,711 patients and provided 1.8 million outpatient visits.

When compared to the other networks, VISN 23 ranks fifth in the number of patients served last year as compared to their rankings as individual networks where VISN 13 ranked 18th, and VISN 14 was 22nd. VISN 23's combined budget represents 4.87 percent of the national budget and ranks 11th among the other networks. Prior to integration, VISN 13's budget was 2.84 percent of the national budget and VISN 14's budget was 2.03 percent. As you can see from these numbers, integrating VISNs 13 and 14 into a larger VISN 23 has not created for the VISN leadership any extraordinary budgetary or workload challenges beyond those currently faced by other VA health care Networks. More importantly, integration has in no way diminished the VA's health care presence in Nebraska or any other area of the new VISN 23. A VISN is simply the administrative structure. Reorganizing that structure will not affect provision of care.

I would now like to highlight several of the benefits to be gained from this merger.

Improved Coordination of care

The two networks share many patients between Nebraska and South Dakota, and Minnesota and Iowa. For those patients that move between the borders, coordination of care will be improved.

Economies of Scale

The merger is expected to generate cost savings through economies of scales. Joint purchasing across the Midwest will bring lower prices for high cost medical equipment and supplies.

Budget Flexibility

Combining the budgets of former VISN 13 and 14 will give VISN 23 greater flexibility in allocating the estimated one billion dollars on VA programs and services. The merger is expected to generate cost savings, and the estimated savings ($1–6 million), over a period of time, will be redirected into expanding access and enhancing services for veterans throughout the Midwest.

Consolidation of Administration Functions

There will be opportunities to implement management efficiencies by integrating fiscal services, consolidating business offices, and materiel service functions, such as contracting, logistics, supply, and warehouse functions. Combining the talents of the staffs of the two former Network Offices (13 and 14) will bring greater efficiency and effectiveness and eliminate duplication. Of the more than 8,000 employees in VISN 23, less than four tenths of a percent (approximately 28 network office employees) will be directly impacted by the initial phases of this merger, although all VISN 23 employees will ultimately benefit from the improved, more viable organization created by the integration.

Clinical Benefits

Access to specialty care in rural areas such as those served by VISN 23 is often limited and traveling long distances to access health care can be a burden to the elderly. The Department of Veterans Affairs recognizes the importance of healthcare providers working collaboratively with veterans and their families in developing effective ways for delivering accessible, high quality health care in rural areas. A fully integrated senior clinical leadership team will seek to understand the veterans perspective and work cooperatively to eliminate or reduce long distance travel for veterans by developing health care delivery systems that will assure equitable access to VA health care across the Midwest.

When a veteran must travel to access care not available at the local VA medical facility, VA considers all available options and discusses with the veterans and family the most appropriate referral site for accessing the level of care needed. Referral patterns in Nebraska have remained the same in recent years and the reorganization of VISN 23 has not impacted on how or where veterans are referred for care. Currently, elective open-heart surgery is provided at the Minneapolis VA Medical Center through a contract that was established prior to the merger of VISNs 13 and 14. An integrated VISN 23 Cardiac Services Task Force is reviewing this current

arrangement and is considering contracting for open-heart surgery in the Omaha, Nebraska area.

Overall, the now VISN 23 will build on the successes of VISNs 13 and 14 and seize opportunities for enhancing quality, expanding access, gaining efficiencies. and improving veteran satisfaction in areas that need improvement. Both Networks 13 and 14 have done excellent clinical work, and we expect that, in combination, the clinical staffs will learn from each other, creating a better and improved health care delivery system.

Today, I am also pleased to report some of the early successes of integration.

Pharmacy and Purchasing Efficiencies

The new Network has been able to identity savings as a result of the joint pharmacy and therapeutics committee's implementation of the use of generic substitutes and laboratory contracting.

Enhanced Mental Health Services

The Network has approved plans to expand psychiatry services in rural areas through the use of Tele-Psychiatry. Included in the plan is the hiring of Psychiatric Regional Care Coordinators in Nebraska and Iowa to enhance coordination of care and Tele-psychiatry services at CBOCs throughout Nebraska.

Improved Business Practices

Recently the Network identified problems within the Nebraska and Iowa MCCF Collections and Fee Basis Units. The Interim Network Director authorized funding for additional temporary staff and combined the resources and expertise of the Business Managers to review business practices and develop a plan for eliminating backlogs and improve business practices. Within the next six months, the Network expects to have the backlog eliminated and plans in place to prevent problems from recurring in the future.

CLOSING COMMENTS

The merger of the two networks should be transparent to veterans. Each medical facility within Network 23 fulfills important missions for VA, and there are no plans to reduce or eliminate VA programs or services in Nebraska or any other state within the network. For the foreseeable future we plan to maintain a network presence in Lincoln. Unique programs. such as the partnerships VA created with community hospitals in Grand Island and Lincoln, Nebraska, to provide acute inpatient medical care, serve as models for exploring new opportunities and creating new initiatives.

The new Network will continue to address a number of challenges, including managing unprecedented growth within appropriated funding; exercising stewardship of all resources; increasing market share; continuously improving quality of care and veteran satisfaction; fully integrating administrative and clinical programs and processes; investing in capital improvements and information technology; and effectively communicating with veteran groups. labor partners, educational affiliates and other stakeholders.

We will monitor the integration process carefully, and I can assure you that service to Nebraska veterans will be preserved. If resources permit, we hope to expand services in community-based outpatient clinics so that we can provide better access for veterans living in rural Nebraska. We expect this integration to provide us better insight for providing care to patients in rural communities, and, as a result, Nebraska veterans will see more accessible and better-coordinated care. I assure you that VA is committed to redeeming the debt we owe to Nebraska' veterans and to all of our Nation's veterans.

Mr. Chairman, thank you for this opportunity to testify.

Senator NELSON. Thank you, Mr. Secretary. Would your preference be to hear the rest of the panel?

Congressman BEREUTER. I'm willing to do that. Thank you very much.

Senator NELSON. Yes. Dr. Petzel.

Dr. PETZEL. I would defer to Mr. Hilgert.

Senator NELSON. OK. Director Hilgert.

STATEMENT OF JOHN HILGERT, DIRECTOR OF VETERANS AFFAIRS, STATE OF NEBRASKA

Mr. HILGERT. Good morning, Senator Nelson, Congressman Bereuter, Secretary Principi, distinguished guests and fellow veterans.

Mr. Secretary, welcome back to Nebraska.

I'm John Hilgert, Director of Veterans Affairs for the State of Nebraska. I am rather new to this position. I became director in late November of last year. Prior to serving the State of Nebraska as Director of Veterans Affairs, I served in the Nebraska Unicameral Legislature as a State senator. Also prior to taking on this responsibility, I worked for 10 years at Catholic Charities of the Archdiocese of Omaha. My background therefore is in government and in private nonprofit behavioral health field. I am a Gulf War veteran having served in the 1st Infantry Division in the U.S. Army.

The merger of Veterans Integrated Service Network (VISN) 13 and 14, was announced on January 23, 2002, and as Director I was made known of many concerns that veterans in Nebraska had regarding the prospect of the merger. Among the foremost of concerns was the access of care for our veterans and the quality of care for our veterans. The prospect of diminished control over limited funds as well as a more distant and therefore less accessible leadership of the VISN was also of great concern.

Since the creation of VISN 23 I must report according to my perspective that the transition directed by Acting Director Dr. Robert Petzel has been fairly transparent. Electronic and written communications regarding the transition have been numerous. Dr. Petzel has visited Nebraska several times and I myself have had occasion to speak with Dr. Petzel in person at least in four instances while he has been in our State. I also report that Dr. Petzel's traveled across our State even attending the County Veterans Service Officer School that was held last week in Scottsbluff. This is very encouraging and helps diminish somewhat the concerns that I had regarding the merger. Communication is essential to a smooth transition.

However, I remain concerned about the allocation of resources that directly impact Nebraska veterans' access to service as well as the quality of their service. To my knowledge, both VISN's and former VISN 13 and former VISN 14 have financial deficits. I have also been told that at least one factor that led to the merger was the prospect of financial savings. I am not convinced that savings through management efficiencies can satisfy the combined deficit of VISN 23. There lies the basis for my concern regarding access of care and quality of care. Simply put, where will the cuts, if additional funding is not forthcoming, be made? I do recognize that this is not singularly relevant only to VISN 23 and there is need throughout the system. I see the challenges that the employees of the Veterans Administration are facing. They are challenged to treat more patients, exceed expectations and at the same time do this with limited staff and limited resources.

Some particular observations regarding access to service and quality of care and please infer nothing by the order of which I make them. A concern or need is the top priority to every individual that is affected by that need.

It has been related to me that there are documented deficiencies regarding the surgery and ICU units at the Omaha VAMC. Additional resources are required to remedy these deficiencies. I do not have the specifics about these deficiencies, but I have been told VA staff that they are indeed documented.

I am concerned about the future of Nebraska's medical centers and community based outpatient clinics. I was encouraged last Wednesday in Scottsbluff when Dr. Petzel observed and volunteered on his own to examine this issue recognizing the great distances that some Nebraska veterans are required to travel to access these services. Although I have been told that there are staffing and budget challenges throughout the system, the Lincoln VAMC stands out in my mind as a particular concern. The Lincoln VAMC plays an important role in service delivery. However, with the loss the VISN headquarters in Lincoln, one can only project a diminished role for Lincoln. There is space at the Lincoln VAMC and I would encourage the administration to use that for a clinical function, clinical function meaning a clinical use rather than an administrative use or function. Personally I would like to see an inpatient dual diagnosis unit established at the Lincoln VAMC. I believe there's an ever increasing need for such a facility in Nebraska. Nebraska has one of the lowest penetrations for PTSD services utilized by our veterans. I believe this also would be a great asset for Nebraska's State veterans homes to refer veterans in order to treat and stabilize those veterans in need of those services before admission into a home. There's an ever increasing acuity among the veterans seeking entrance into our State veterans homes. Obviously I would encourage and support any use of that space that translates into greater service for Nebraska's veterans.

There is also a need for additional clinical pharmacists in order to support our physicians. I believe this would result in time savings for the doctor, freeing her up to maximize time with the patient directing addressing the whole health needs of the patient. Quality would be enhanced as well as probable financial savings. I have been encouraged by reports of cooperation between the two former VISN's in this area, the willingness of former VISN 14 to adjust their formula to match former VISN 13's.

It has been recognized by the VISN 23 leadership that the greatest challenges that VISN faces is the large geographical area, the employees and veterans travel distances, the budget shortfalls, the large number of Priority 7's and the infrastructure maintenance costs. This recognition is very encouraging.

These are some of my observations that I have made in my short tenure as director of Veterans Affairs for our State. I look forward to continuing the dialog with VISN 23 officials. I look forward to working with the VA as we address the issues concerning the Thomas Fitzgerald Veterans Home in Omaha. I look forward to working with the VA as we continue to work toward the establishment of State veterans cemeteries in Alliance and in Grand Island. It is with great pride and confidence that all Nebraskans can rely on the oversight by Nebraska's congressional delegation.

There are many concerns that remain among Nebraska veterans and you will hear from them today. There are many challenges facing VISN 23 as well as the entire system. Extensive communica-

tion must be maintained. Access should not be diminished, but rather enhanced and quality must always be top priority. The system, no matter what the management style, organization or by what moniker it is called must always, always be veteran centered.

Thank you for the opportunity to share with you my observations. Thank you, Mr. Secretary, for coming to our State and thank you, Senator Nelson, for convening this field hearing in Nebraska for Nebraska's veterans. Thank you.

Senator NELSON. Thank you, Director Hilgert.

Dr. Petzel.

Dr. PETZEL. I have no prepared remarks, but am here and available to answer questions.

Senator NELSON. That would be fine.

Mr. Nugent.

Mr. NUGENT. Mr. Chairman, I have no prepared remarks, but I would be more than happy to answer any questions.

Senator NELSON. Thank you. I'll defer to my colleague for the first questions.

Mr. BEREUTER. Thank you very much, Senator.

Secretary Principi, I wonder if I have made clear my basic concern about VERA, that there must be an underlying structure, a minimum structure at least providing quality care throughout the whole country even though the veterans are piling up the sun-belt States with their political clout which keeps us from changing the formula because of the large population in the south and California and Texas and Florida today that there must be a very basic structure of delivered services throughout the whole country, even though the number of veterans in this region are proportionally quite small and therefore the funds coming into this area are therefore very limited.

Mr. PRINCIPI. Mr. Bereuter, you have made your point very clear and I hear what you're saying. I too agree. As I travel the country, and this is my second trip to Nebraska, Kansas, and the Heartland, I too am concerned about rural health care and to ensure that we have adequate resources that are coming to places like Nebraska to care for veterans who for whatever reason can't get down to the sun-belt and retire are here working on the farms or whatever.

I think the VERA model generally speaking is a good model, it does fund workload. There have been supplementals that have gone to former—the VISN 13 in the past. We are looking at refinements of the VERA model to make it more equitable to address some of the issues that you have mentioned. But generally speaking, I hear the points you're making. I think it's a very, very important one and something that needs to be addressed to ensure veterans in rural America are not suffering as a result of this model.

Mr. BEREUTER. Mr. Secretary, thank you for your recognition of this problem. If it's impossible for us to change the allocation system, thus far we have been unable to do that by legislative requirement because of the limited number of votes we have in the Northern Great Plains and the Northern Midwest. Is it possible that we can rely more heavily on outpatient clinics which I think are moving into the right direction? Can the funds for the outpatient clinics be considered separately for sparsely settled parts of the Nation?

Mr. PRINCIPI. I think that's what we need to look at. Now, we have 37 or 35——

Dr. PETZEL. Thirty-five.

Mr. PRINCIPI [continuing]. Thirty-five outpatient clinics in the new Network 23. There were nine community-based outpatient clinics in the old Network 14 and that may be the answer. Our goal is to have an adequate number of community based outpatient clinics within 30 miles of a veterans home. That way veterans can access the VA health care system and they can use that as the entry point. If they need complex inpatient care, they can then go to one of the urban hospitals which may be a little further from their home. But I believe that by consolidating some of those complex surgical procedures, it has been proven that the quality is much better as a result.

I think that's been true in both the private sector and in the VA. When, for example, you have consolidated open heart surgery and providers do more surgical procedures, the quality becomes much better. Today we have a moratorium on opening new clinics, until the budget situation is clarified. But that is something that I will look very, very seriously at—to see if there is a need for outpatient clinics in this area and to see if it is possible for us to either expand existing ones or open new ones as the 2003 budget becomes more.

Mr. BEREUTER. Mr. Secretary, we would very much appreciate that. I know in the Heartland—in contrast of having a clinic available within 30 miles of every veteran, we'd feel very good if there was one within 60 miles of every veteran, in many cases, of course, the alternatives are much longer as Director Hilgert pointed out, our problems are the travel time for the veterans and for their families to visit. The history is, of course, that we have had two hospitals out of the three close in this State, the ones in Grand Island and Lincoln, and so it is the Black Hills, Hot Springs, South Dakota, or Denver or Omaha that are the alternatives for inpatient care.

There was a very interesting case which I think presents our concerns about whether or not a consolidated VISN headquartered in the Twin Cities is really going to understand and be sympathetic and address the problems that we have. I will give you this example. It made quite a newspaper story.

A veteran living in west central Nebraska, not in my district, in Congressman Osborne's district and, of course, constituencies of our two Senators as well, the poor man was suffering not only from physical problems that required pharmaceuticals, but from Alzheimer's as well, and in order to get his prescriptions renewed on an annual basis to be given the kind of scrutiny by a physician to see if, in fact, those prescriptions were still appropriate, the man has to travel to a veterans hospital or at least perhaps to an outpatient clinic like the one in Lincoln, but this woman cannot even with help take her husband to those clinics, she physically—because of his Alzheimer's problems and the travel difficulties, and so she's faced with a very high prescription by going to a local doctor and not being able to get the prescription filled by the VA. So it occurred to us as we looked at it in the initial stages, well, you could have your VA people basically doing circuit riders around the

State to handle those kinds of extraordinary situations which are unfortunately not unique, not too uncommon where it's a difficulty to come in even annually for a reexamination to renew the prescription, or second you could permit local physicians on a contract basis in that community to do that work for the VA.

This woman has no alternative with her husband in the current condition for getting his prescription renewed so she can get VA prescriptions, and that is just something that came to our attention. We were looking for a legislative solution, but really an administrative solution just presents itself very clearly to one when you think about that, permitting a doctor on a contract basis to do very basic kind of examinations and prescription renewal in isolated parts of our State. Do you have any reaction to this problem?

Mr. PRINCIPI. Well, certainly. In that specific case, if the veteran is enrolled in the VA health care system—other than periodic exams—all of his prescriptions should be mailed to him there. We have a wonderful consolidated mail-out pharmacy program, so——

Mr. BEREUTER. Secretary, excuse me for interrupting, but it is the periodic exam that is the problem.

Mr. PRINCIPI. The problem.

Mr. NUGENT. I'm actually familiar with this case and I think someone from Congressman Osborne's office contacted us and when we were aware of it, we tried to get a physician up there and I believe that we can supply the information for the record, but we were going to either send one of our staff up or contract with one of the physicians in the area to go out and see this particular veteran.

Mr. BEREUTER. I wish you would consider one of those two. This just happens to be a notorious case that made the paper, but there are others.

Mr. Chairman, Senator Nelson, thank you, and I'll turn to you for your questions, of course.

Senator NELSON. Thank you, Mr. Bereuter, and again, thank you, Mr. Secretary.

What the veterans are concerned about is any kind of reduction in the quality or quantity of services or in their ability to deal with the administration of those services. So it's both about clinic and management that we are here today. Obviously the more distant the administrative headquarters is the more concern people have about how you deal with that administration, how you're going to interface with them to make sure the quality and quantity of services are not reduced. So I'm encouraged, Dr. Petzel, by Director Hilgert's comments about your having been in Nebraska a lot and we hope that that will continue. Obviously we would love to have you be a Nebraska resident, but we want you to be a near resident and qualify for our income tax laws.

That's how much we want you to be here because I think that's the heart of what this is about today in terms of veterans. I mean, we don't have to go through why veterans are entitled, maybe not under the law, but morally entitled to these kinds of services. We don't need to go through that, everybody in the room understands that and everybody outside the room understands that. How we deliver it is so critical. Our concern is that we have reassurance that

there won't be any reduction in the quality or quantity of either management or clinical care and/or services that they're entitled to.

Is there anything that the Secretary can tell us specifically that might help us have that kind of reassurance beyond where you are at the moment? For example, I think that there was a location issue that's been raised and one of the recommendations in the business case study was to establish a satellite VISN 23 office in Nebraska for the transition process. Has that been accomplished and is there something that might take us beyond that transition office?

Dr. PETZEL. Thank you, thank you. There is a plan to have a satellite as you put it network office in Lincoln. We will maintain a presence as a network office for as far into the future as I can see. We've not done anything definitive, we won't until there's a permanent network director named and we begin the actual process of consolidating the network offices, but it's already been identified that there is a need to maintain that.

I should also add that my wife thinks I spend more time in Nebraska now than I do in Minnesota since the 23rd of January.

Mr. PRINCIPI. Well, I can certainly commit to you, Mr. Chairman, Mr. Bereuter, that I will watch the situation very, very carefully. I intend to hold my people accountable to ensure that resources are equitably distributed just as I expect you will hold me accountable in the discharge of my responsibilities as head of the VA, but I believe this is a good management step that we have taken. We have two relatively small networks. We know we have a declining veteran population across the country as the World War II population passes on. We are just trying to take good management steps to ensure that we are stewards of the public trust—of the taxpayers' dollars, that we are spending those dollars wisely, efficiently and effectively across the country and, as you have indicated, to ensure that the veterans across the country have equitable access to the VA as best we can. Now, you can't do it in every community in America, and certainly there are stories of factories closing down and veterans not having health care or there is no VA facility in an area etc. Those are always very heart wrenching. But I think to the degree we can, we have tried to move health care closer to the veteran. Of course, 30 miles in transiting Chicago or one of the larger areas is a great distance. It probably takes you as long to go 60 miles, as you have indicated, out west, where you don't have as many traffic lights or congestion, but we are trying to ensure that access to health care is equitably distributed.

Mr. BEREUTER. One final question, Mr. Chairman. Secretary, with the shortfall last fiscal year, $92.7 million, is it worth all of the concerns that we are going to fail to have adequate administrative contact and concern to save $600,000 or at the most $6 million, which is the highest estimate I have seen and isn't this a very minor savings as compared to a huge problem that this VISN region faces even in a more populated area of VISN 14, 13 combined? $92.7 million shortfall in 1 year suggests there's something basically wrong with the allocation system, I believe.

Mr. PRINCIPI. Mr. Bereuter, you are absolutely correct. This is really a very, very small issue relative to the larger issues facing the VA health care system. I don't know how else to say it. I have

never seen anything else quite like it. Now, I have been in and out of this business for 20 years since I first went to the U.S. Senate, starting with the Armed Services Committee and then Veterans' Affairs Committee and then with President Bush One. I get a call every day from a Member of Congress. I mean, from Florida to Seattle, WA and everyplace in between. We have more and more veterans coming to us for care and, you know, the waiting lines are growing longer.

The clinics we opened just a year or 2 ago, and which we thought would not reach capacity for several more years, are at capacity. As I indicated, we are treating a million more veterans today than we were treating just a short time ago. So, we do have a serious issue here and it's just not in Nebraska, it is everywhere.

Mr. BEREUTER. Is this shortfall of $92.7 million for fiscal year 2001 the largest shortfall in the region on a per capita basis in the whole country?

Mr. PRINCIPI. No, I don't believe so. We have much larger shortfalls in other parts of the country.

Mr. BEREUTER. On a per capita basis?

Dr. PETZEL. Yes.

Senator NELSON. Dr. Petzel, maybe you can——

Dr. PETZEL. We do in New York and Boston, both of those places.

Mr. BEREUTER. No wonder they are always helping us when we try to bring this issue to the floor.

Dr. PETZEL. Oh, yes, yes. They have the same serious problems as we do.

Mr. PRINCIPI. Now, the good news is that the Congress—the House has just marked up a supplemental appropriation for 2002 for the VA. We had requested $142 million in additional funding for the VA health care system. We now have that figure up to $417 million for 2002. That, combined with some of the management steps we have taken, such as procurement reform and information technology spending, if we get that amount as it goes through the Senate, we will be fine for 2002. Much of that shortfall, I don't want to say every penny of that shortfall, but much of the shortfall in places like VISN 23, will be offset by that supplemental.

For 2003, it's another set of challenges. We have requested about a $1.6 billion increase in VA health care alone. I think Congress is looking to add to that budget. So will it be enough? Maybe not, but I think we're moving in the right direction. So I think the shortfall will be offset by the supplemental.

Senator NELSON. Mr. Secretary, my question is in the form of cost containment. What can be done to control costs, where they are controllable, not by taking away services, but by making sure that utilization severity and the provision of services is appropriate to the conditions? Ordinarily when you have a centralization of authority and you pull people away from an area where they can otherwise watch it more closely, wouldn't this argue for more decentralization? Somebody closer to the scene could watch the dollars a little bit more closely and watch the provisions of services to make sure that they are appropriate and cost effective?

Mr. PRINCIPI. Well, that's a good question and I may—Dr. Petzel may have a little different take on it because he's in the field, but I don't pretend or believe that you can centralize all of manage-

ment in Washington, DC or corporate headquarters in the private sector. I think there needs to be a balance between in our case Washington, DC and the field. You have to manage health care closest to where the patient is, but at the same time, I think in some instances we have decentralized too much and we have 21 separate health care systems all competing against one another for the dollars and without recognizing this is a zero-sum gain. At the end of the day, you give us an appropriation, and we have to allocate that appropriation across the country. Maybe at one time, we had medical centers competing against one another, but now we have networks competing against one another for those dollars, and we have this imbalance. I like to look at it as kind of a Federalist approach but you've got to balance it. Washington has to make the policy, has to oversee the operations to make sure it is equitable and then allow the people in the field like Dr. Petzel, who really understand health care and understand their network in accordance with those guidelines, to distribute the dollars and manage the workload.

One thing that the president told me that has stuck with me, he said, "You know, every dollar we spend is a dollar that some American has to send to us, take out of his or her pocket and send to us." In my case, I'm the steward of those funds, and I have the responsibility to ensure that those dollars are spent wisely and effectively. Compassion is not how much money we are spending; compassion is measured by the results we get. That's basically what I am trying to do as Secretary, to ensure that we are spending the dollars, and those dollars are reaching veterans. The only reason we exist is to serve veterans, and I take that responsibility very seriously.

Mr. NUGENT. I wonder if I could add just one comment——

Senator NELSON. Sure.

Mr. NUGENT [continuing]. From just the operational aspect of the hospital system. The creation of these small cells creates problems for us as well. Three or 4 weeks ago, we attempted to get a patient into another network only to be informed that they didn't take patients from our network. Now, we were able to resolve that with some help, but it does create a level of competition that I think is unhealthy and creates different levels of care across the country.

Senator NELSON. Thank you very much, and Secretary Principi, will you please join us here.

Mr. BEREUTER. Senator Nelson, I need to go back into my schedule around Lincoln. Thank you so much for permitting me to be part of the Senate Veterans' Affairs Committee hearing today. I am leaving my Veterans' Affairs caseworker, Jeanie Walker, back here who will give me full reports on what has been said here and the kinds of things that we might need to do to help. Thank you for inviting me.

Senator NELSON. Well, thank you very much, Congressman Bereuter. It's a pleasure to have you here. It certainly makes this a bipartisan effort. Thank you.

We'll just take a second or two here to invite up the second panel which I might introduce as the name cards are being changed. We have Elaine Bernhardt who is the President of American Federation of Government Employees, Local 2601; Mike Crawford, the

President of American Federation of Government Employees, Local 2270; Keith Fickenscher, the Executive Director of Tabitha Health Care Services—the former Director of the Department of Veterans Administration Affairs in Lincoln; Jim Cada, the Chairman of the Inquiry and Review Board of the Nebraska State Veterans Home, and Dr. Jane Potter, Harris Professor of Geriatric Medicine, the Chief of the Section of Geriatrics and Gerontology, the Department of Internal Medicine at the University of Nebraska Medical Center. Doctor and everyone, we are very delighted to have you join us here today. We will start first with Ms. Bernhardt. If you would share with us the concerns you have on behalf of the employees.

STATEMENT OF ELAINE BERNHARDT, PRESIDENT, AFGE LOCAL 2601, GRAND ISLAND, NE

Ms. BERNHARDT. Thank you, Senator Nelson.

My name is Elaine Bernhardt. I'm the President of Local 2601 AFGE in Grand Island. When I first talked to Eric Pierce about this hearing today, he asked me to identify some opportunities that I could associate with integration. That was 2 weeks ago and I haven't been able to do that. I have been racking my brain and I just can't think of very many opportunities. But the second thing he told me was that if I identified some problems, if I could please identify solutions at the same time. That's been even tougher. I think the budget crisis—and I understand what the Secretary was saying earlier, we have an appropriation we have to live with—but I do have to question the distribution of that budget. I think Nebraska has suffered tremendously under the old administration of VISN 14.

There was a deficit in VISN 14. Nebraska was to assume $4 million of that deficit as compared to $300,000 that Iowa City was to assume.

As it is now, under Dr. Petzel's leadership, he did put $7.7 million into the Nebraska budget that wasn't there before, but that still leaves us with a deficit of close to $7 million. It doesn't equate to me, but then I'm not a mathematician either.

We've take some measures in Nebraska to deal with the deficits. Some of the things that we have done is curb our pharmaceutical costs. We have limited travel, particularly employee travel for education. We've done some other things. FTEE ceiling, we have limited that and we have cut some of the control points. Every control point has been cut.

What happens is that the employees recognized that they're not going to have those positions filled, so that person is gone who used to work beside them—and there's not enough money in the control points to even buy arm bands for our VA officers when a fellow officer was killed on duty in another part of the United States. Instead what they were told to do is take a piece of electrical tape and put it on their badges. That's pretty tacky.

We need to take a look at the budget and the distribution, and what is that telling the employees. How they feel about this right now is that yeah, there's a lot of things wrong with the integration because these things weren't happening before. There was a hiring freeze, but now their nose is being kept to the grindstone and they are not able to travel for education. And that's where the rubber

meets the road. Those are the people that the veteran sees and who they deal with when they come in for attention. We need someone in Grand Island—every one of the facilities in Nebraska—in a visible place to answer some of the questions that the veterans have. Right now if they have insurance questions or they have billing questions, what they do is call a number and nine times out of ten they get a voice mail, they leave their voice mail, the calls are not returned, their billing questions go unanswered. If they go to triage, they have to call Des Moines, IA, and that's really a tough one to answer those health questions or tell those veterans they can indeed go to a private hospital for their care if it's an emergency in the case of Grand Island.

Those are the things that need to be looked at very, very hard and we need some answers. I don't have the answers to the problems. I mean, it's easy to throw resources at things when you have the resources, but we don't have them. So what I have managed do is identify some problems. I don't really have any solutions other than give us more money. And with that, I will close.

[The prepared statement of Ms. Bernhardt follows:]

PREPARED STATEMENT OF ELAINE BERNHARDT, PRESIDENT, AFGE LOCAL 2601, GRAND ISLAND, NE

OPPORTUNITIES FOR VA NEBRASKA/WESTERN IOWA HEALTH CARE SYSTEM WITH THE INTEGRATION OF VISN'S 13 AND 14

Mental health

Not unlike other health trends, it has been found that most patients respond in a more positive manner when treated in a non-institutional setting. The current Mental Health Outreach programs in Nebraska are successful but are grossly understaffed and under-funded. Veterans in rural Nebraska would benefit from expansion of this program and the VISN would realize compliance with DVA performance standards.

Extended care

This field encompasses all aspects of expanded care for the aging veteran populace. The Nursing Home Care Unit in Grand Island provides transitional care and terminal care for veterans in the entire state. The renovation project will satisfy this need for a few but as the veterans age, the demand will grow. Nebraska communities are unable to keep up with the present day demand and it is not expected they will meet future private needs for long-term care yet alone, veterans' requirements. The vacant building in Lincoln could be utilized for Geropsychiatric care, and/or an Alzheimers Unit, but the building needs to be equipped with an adequate sprinkler system. The projected costs for this project have been largely inflated. All three Nebraska VA buildings could be utilized for Adult Day care, Hospice, Geriatic Evaluation Units, Geropsych, Alzheimers. etc. There is adequate space in the main hospital buildings on all three sites if offices were moved to vacant outlying buildings.

Community based outpatient clinics

These clinics, have proven to be expensive for the VA to maintain. It is expected that the expense will increase as medical costs rise. The most expensive method of providing this benefit is through contracts with community health providers. This process limits the number of veterans that can be in the community panel and once established, is subject to the providers' demands when the contract is renewed. For example, the Norfolk Community Based Outpatient Clinic is limited to approximately a 300 veteran panel with limited number of visits per year and has recently increased the cost of care for this panel. The North Platte Clinic provides this service to approximately 1500 veterans with unlimited number of visits and at a much smaller expense. VA staffed CBOCs seem to be the answer.

There is the threat that the Lincoln facility will be downsized to a minimal service CBOC. This cannot happen if we are to continue to provide high quality, efficient outpatient medical attention at a minimal cost.

Transportation

The Nebraska VA Transportation Network benefits veterans in rural Nebraska by bringing them into the Outpatient Clinics at all four VA-staffed Outpatient Clinics. The van runs include O'Neill, McCook, North Platte, as well as Grand Island, Lincoln and Omaha. VA employees and Veterans Service Organizations staff the transportation system. The system is in need of constant refining and is in dire need of more staff. Presently, higher-paid tradesmen are covering for drivers' absences. This occurs, nearly daily in Grand Island.

Staff issues

Nebraska/Western Iowa HCS has employed various methods to recruit staff in the field of nursing but the national shortage is felt at all three campuses. The few retention incentives available are subject to supervisory initiation/approval and we monetary only. In Grand Island, there is a movement to provide quality, affordable Day Care in a vacant building, which will aid greatly in recruitment and retention efforts. Day Care Centers in Lincoln and Omaha would provide the same incentive.

The staffs in all three facilities have been taxed during the past several years. The hiring restriction that was imposed last summer remains as NWI is limited to a cumulative FTEE level of 1302. Ninety Nebraska positions need to be cut in order to adhere to the FTEE ceiling. At the same time, ceilings on overtime usage have been imposed and budgets for each department have been decreased. These constraints have placed a huge burden on the employees; consequently the initial impact from the integration has been negative.

Although our FTEE levels are perceived to be high (down 19% in the past five years) the personnel cost for medical care per patient is less than the national average. The median salary in VISN 14 was the lowest in the nation, and the Nebraska side of the VISN average salary was lower than the Iowa side.

Communication

The communication and referral process between and among the three NWI campuses is in dire need of improvement. Follow up responsibility in shifted from campus to campus while the veteran awaits word on the results of testing or what is to be done next. Procedures for early detection of any medical condition need to be performed quickly, not delayed for three months, which is often the case when we limit ourselves to the Omaha VA.

Customer satisfaction

Veteran satisfaction would increase drastically with implementation of the following:

- A designated Customer Service Representative at each campus. This person would be placed in a visible area to answer questions from our veterans. Presently, veterans are required to call a voice mail number in Omaha for billing and insurance questions and often their messages are not returned.
- Insurance information needs to be obtained at time of eligibility determination and when VA patients are seen at the contract facilities. Many months can pass before insurance information is obtained and in the meanwhile the patient pays full co pay amounts and interest accrues.
- Realistic establishment of panel sizes for providers. Presently, the panel size is undetermined, as a satisfactory "formula" has not been developed.
- Presently appointment times for established patients are 20 minutes. For the reason that our clientele in older and sicker than the private sector, these times need to be increased to 30 minutes with one hour appointments for more complex now patient exams.
- We need a hospitalist at each contract hospital. On an average, we house 12 patients a day at St. Francis Medical Center. The Medical Officer of the Day is currently responsible for inpatients at the contract hospital while still maintaining his/her regularly scheduled clinic appointments.
- Ancillary services personnel need to be increased as the FTEE in these services have stagnated while the number of providers and number of uniques has increased drastically.

Opportunity for research

With the integration comes the opportunity for the highly-acclaimed Minneapolis VA Research Department to expand their subject clientele and research issues to include the aging veteran population in a rural setting.

Opportunity for fair and equitable consideration

NWI has endured the short end of a biased VISN administration prior to the VISN 23 management. With the new management comes an opportunity to target

incentive and recruitment dollars for distribution to the front line rather then bonuses for VISN Managers that ranged anywhere from $5000 to $20,000. Presently, travel dollars are restricted and most bargaining unit employees are not approved for travel associated with training. No other facility in the new VISN 23 experiences these restrictions.

Senator NELSON. Thank you.

Mr. Crawford.

STATEMENT OF MIKE CRAWFORD, ENGINEERING EMPLOYEE, NEBRASKA-WESTERN IOWA HEALTHCARE SYSTEM (NWIHC), OMAHA, NE

Mr. CRAWFORD. Senator Nelson, Secretary Principi.

My name is Mike Crawford and I am an engineering employee for the Nebraska-Western Iowa Health Care System at the Omaha facility. I have worked there for over 20 years and have 26 years of government service. I also serve as President of the American Federation of Government Employees, Local 2270, representing approximately 600 dedicated and hard-working employees at the Omaha facility.

I want to thank you for giving me the opportunity to voice some of our concerns regarding the integration of Networks 13 and 14.

During my over 20 years, we have seen our share of changes. We have gone through districts, regions, local authorities, statewide mergers, VISN's, independent CBOC's and now merged VISN's. Just one more change in a long line of changes.

For years it has been rumored that VISN 14 was going to be dissolved. There has been talk of sending us to at least three different VISN's and even talking about splitting Iowa and Nebraska and sending each State to a different VISN. The reason has always been the same, VISN 14 has been operating with a budget deficit. It is common knowledge that in fact there are 15 VISN's that are currently operating with a budget deficit. Therefore I maintain as I always have, that the VISN concept has not worked since its inception and however well meaning, this merger will not work either.

In Nebraska we have seen our wait times for our veterans increase at a substantial rate, up to 9 months for some of our specialty clinics and Veteran Satisfaction Surveys have fallen because of it. A lot of this is due to the continued increase in our patient workload. When compared to fiscal year 2001 workload, our fiscal year 2002 outpatient visits are expected to grow by 6 percent and we anticipate seeing 187,000 patients in our clinics. Once our new outpatient exam rooms are open, we will be able to see more patients in a timelier fashion. But if we are not allowed to increase the needed full-time employee equivalent, FTEE, to care for them, the increased workload will only prove to compound our problems.

Because of both parochialism and political pressures on VISN 14, I believe that the Nebraska facilities have suffered unnecessarily under the policies of VISN 14. I would like to lay out some specific examples:

As far as staffing is concerned, in comparing the Omaha facility with the Iowa City facility, excluding CBOC's, we find that Omaha reported more patient days, discharges, outpatient visits and encounters than Iowa City, but Omaha was expected to do this with 65 fewer FTEE's. The impact on Omaha has seen increased use of

overtime, mandatory overtime, increased use of contract nurses which we all know equates to extremely high costs, restricted number of ICU beds, employee burnout and low staff morale.

Mr. Gary Nugent, our current Chief Executive Officer, upon arriving in Omaha noted the staffing issue and began taking action to correct the problem. At the insistence of VISN 14, all facilities in VISN had to do a comparative bottom-up review with like facilities. This information has not been used but does indicate the need for additional staffing to meet our increasing workload. About 6 months ago, VISN 14 placed the Nebraska-Western Iowa Health Care Divisions on a hiring restriction. All positions after being reviewed by local management had to be referred to senior management at VISN level for recruitment approval. It seems absolutely ridiculous to me that we would have VISN senior management officials spending time to determine if we should be filling housekeeping positions in our facility. Is that not part of the local facility director's responsibilities to ensure that we have the proper level of staff. We saw this same form of VISN control play out at the Kansas City VA and we certainly don't want a repeat of the embarrassment that occurred there.

In 2002 VISN 14 budget allocation process, the Nebraska-Western Iowa Health Care System allocation was cut by more than $4.2 million from its budget request and the Central Iowa Health Care System was cut 6.1 million, yet the Iowa City facility was asked to only cut 300,000. Again, we have comparable size and workloads, but disproportionate budget allocation. Another interesting fact is that in the Iowa City budget allocation was an additional 2.5 million to deal with their backlog in getting patients into clinics. If you would look at the backlogs in Central Iowa and Nebraska you could justify the same infusion. When you compare the Iowa City and the Omaha campuses workloads, you will see that Omaha had the larger inpatient and outpatient workload, but Iowa City before the infusion already had 30 more physicians on staff. Why did they need an infusion? Logically you would think that with 40 more physicians than Omaha there should never have been a backlog.

In VISN 14 there continues to be staff mix and pay grade disparity between network facilities. Employees find it difficult to understand why a position in Omaha is graded lower than like positions at another VISN 14 facility. My many requests for physician standardization have fallen upon deaf ears. This contributes to the low morale, low job satisfaction rating and mistrust among VISN 14 facilities.

I believe that there will be no significant cost savings associated with this merger. In fact, I can see increased costs, for example, travel. Nebraska-Western Iowa is required to send officials to Minneapolis to discuss the merger. To meet this financial demand, the employee education money and employee travel fund will be used. Has this same practice been instituted throughout both VISN's or will just the Omaha employees pay the price? Did anyone at the VISN level ask central office for financial relief for this mandated travel? This will not only increase the deficit at the Nebraska-Western Iowa Health Care System, but penalizes the education and travel fund set aside for employees.

One of the noted goals of this merger was that all VISN staff would be retained. VISN staff will most likely need to be absorbed into local facilities. It was also announced there will need to be some form of VISN staff left in the Lincoln facility while the major VISN staff will be located in Minneapolis. Again, logically this does not seem to make much sense. There will be the cost of maintaining the property, office administration and obviously duplicated positions.

Currently VISN 14 reports that it has a staffing level of 16 FTEE. This is inaccurate. All facilities in VISN 14 have staff working full time for the network that are costed to the local facility and counted against their FTEE. Local management has no authority to delay or disapprove filling these positions, but is held accountable when they exceed their assigned FTEE ceiling.

I believe the million dollars being spent in the operation of a VISN could be better utilized in providing health care to our veterans. I would propose that instead of an integrated merged VISN, we would look at having a regional chief executive officer, fiscal officer and medical officer. We should allow our facility directors to utilize their training, experience and expertise to operate the local facilities in the best interest of the veterans they serve. These directors should be held accountable for their actions to the three regional directors I have previously mentioned.

Finally, I want to assure you that no matter what direction the VA takes in the proposed merger, our employees will continue to provide the high quality health care this Nation's veterans have earned and deserve. We must honor the commitment this Nation has made to its veterans. Again, thank you for giving me the opportunity to speak before you.

Senator NELSON. Thank you.

Keith.

STATEMENT OF KEITH FICKENSCHER, IMMEDIATE PAST DIRECTOR, VETERANS AFFAIRS FOR NEBRASKA

Mr. FICKENSCHER. Thank you, Senator Nelson, Secretary Principi. I am pleased to be here. I think I bring kind of a historical perspective, having been through a lot in this VISN during my tenure as Director of Veterans Affairs from 1996 until just about 10, 11 months ago.

In July 1996 I was appointed Director of Veterans Affairs for Nebraska by Governor Ben Nelson. Change was just beginning to occur in the care model for VA medical centers across the country. Those Nebraska veterans who were eligible to use the system, were very proud of our State's three VA medical centers in Omaha, Lincoln, and Grand Island. Quality of care and compassionate service were both highly acclaimed. The only significant dissatisfaction that I recall came from those Category C, now Priority 7 veterans, who were denied access to the VA health care system. They felt strongly that their government had made implied and explicit promises of perpetual health care for them in exchange for their service to their country. As a group, they were pretty upset about the way the VA health care system denied them access.

In my early months as Director, the three VA hospitals in Nebraska were operated pretty much independently. However, there

was a lot of information coming from the system indicating the financial picture, especially for Grand Island, was not good. There were rumors about closing Grand Island, which was an option vehemently opposed, especially by veterans west of Kearney. Eventually the solution the VA recommended was to integrate Grand Island and Lincoln. This was supposed to solve the financial crunch. At the time, I recall veterans being very skeptical because there was a belief that Grand Island was a cost efficient operation operating in the black, whereas Lincoln was not. A year later, the deficits were still piling up and there was a push to integrate Lincoln and Grand Island with Omaha. Veterans were wary because the previous integration had resulted in the loss of inpatient medicine, dialysis, ICU and telemetry at Grand Island. Surgery at Grand Island had been previously discontinued. The argument used by the VA for integrating Lincoln and Grand Island with Omaha was that the inpatient and surgical census at Lincoln did not warrant continuation of those services. Veterans believed the VA had perpetuated a self-fulfilling prophesy. By excluding care to large groups of veterans, their inpatient numbers were dwindling. Nebraska veterans felt they had given up enough with the loss of services at Grand Island and they did not want to see the same thing happen at Lincoln, but it did. With the integration of Lincoln and Grand Island with Omaha, Lincoln lost acute inpatient medicine, general surgery, urology, orthopedic, psychiatry, and substance abuse rehabilitation.

Throughout the process of both integrations, Nebraska veterans were given five consistent messages by the VA: No. 1, the result would be seamless to the veterans, they would never know it; 2, savings from integration would be put back into the system to provide better health care; 3, the VA would have contracts with the local hospitals, St. Francis in Grand Island, St. Elizabeth's in Lincoln, to provide care to veterans when transportation to Lincoln and then later Omaha was not in the patient's best interests; 4, the VA would operate an extensive transportation network in the State to transport veterans to the appropriate VA facility; and 5, veterans were told that they needed to encourage their comrades to enroll in the VA health care system to get the numbers up and thereby get a bigger piece of the VERA revenue pie for Nebraska.

Taking these points in order, the actual affect on veterans was quite different from what they believed they could expect. First, the changes that were implemented were not seamless, they resulted in a concentration of services in Omaha, making care much more inaccessible to outstate veterans; second, there never were any savings. Every year veterans were told new horror stories of the burgeoning budget deficits in Nebraska's three VAMC's and in VISN 14. If no savings were realized from the previous two mergers, we wondered why this one would be different; third, the process to obtain care in a non-VA facility was never well understood, which resulted in veterans being stuck with medical bills and ambulance charges they thought the VA was going to pay; fourth, and to this day, I am told the VA transportation system is no better than it was in 1997 when Grand Island was integrated with Lincoln. A veteran in western Nebraska is not likely to believe that an administrator in Minneapolis is going to fix this problem; and fifth, Ne-

braska veterans responded to the invitation to enroll their comrades.

As I recall in one particular year, Nebraska led the Nation in enrollment percentage increases. The problem was most of them were Priority 7's and the VA then began telling us these Priority 7 veterans were bankrupting the system because VISN 14 did not receive any reimbursement for providing them care. Furthermore, we were told the additional enrollment of Priority 7 veterans was creating a huge burden in the cost of supplying them their prescription medications. So in effect, by doing exactly what they were asked to do, Nebraska veterans helped increase the deficits and put more pressure on cutting costs in VISN 14.

I recall a discussion I had with a county service officer who told me he wasn't going to enroll any more Priority 7's because every time he did, he was contributing to the demise of the VA health care system. In a tragic and sad way, he may have been right. This VISN even canceled scheduled health screening clinics because they produced too many new enrollments.

Given this historical overview, which admittedly has omitted many veterans' frustrations involving emergency care situations, transportation, lodging, billing errors and extraordinarily long waits for appointments, I believe it should be apparent why Nebraska veterans might mistrust yet another integration. Hopefully, there are no plans this time to strip any more services or product lines out of Nebraska.

So where do the efficiencies arise? We could conceivably eliminate the VISN director for Nebraska and Iowa and the VISN office in Lincoln. That wouldn't be enough.

As this integration goes forward, Nebraskans deserve to be told the truth, Mr. Secretary, up front about what will happen to their facilities and services. They deserve a commitment to a plan that will resolve the transportation problems. They deserve to have clear, consistent rules about when and how they can access care outside the VA system and still expect the VA to pay for it. They deserve to have Medicare cover the cost of their care. They deserve to have an associate director at their facilities in Omaha, Grand Island and in Lincoln. And finally, I don't know if they deserve this or not, but it would be awfully nice if whenever they called their VA medical center regardless of the time of day, a live, helpful and knowledgeable person would answer the phone. I think it is disrespectful to those who have served this country to expect them to deal with an answering machine when they have health-related concerns.

Senator Nelson and Secretary Principi, thank you for this opportunity to present my views to you. And in ending now, I would just add that I do say that you have a great group of people in Nebraska. It was a great honor for me to work with people like Gary Nugent, Ken Huibregtse, Cindy Sestak, Dr. Graham and I always admired Dr. Petzel from afar, as a great leader. You have the right people here, but they just simply don't have the resources to do the job that they want to do.

Senator NELSON. Thank you.

Jim.

STATEMENT OF JIM CADA, STATE COMMANDER, MILITARY ORDER OF THE PURPLE HEART, NEBRASKA DEPARTMENT, LINCOLN, NE

Mr. CADA. Thank you, Senator Nelson, Secretary Principi.

In January I presented a letter to Secretary Principi and to the Nebraska congressional district and other members of the Senate Committee on Veterans' Affairs, a copy of the letter has been provided and the information in that letter continues to be correct and the questions asked therein are still unanswered.

As the State Commander of the Military Order of the Purple Heart, I am here today as a veteran that is deeply concerned for the care of all veterans. In the late 1990's as Senator Nelson discussed, we had some studies and those studies showed that the merger would not bring any benefit, either for the patient or for the financial situation. So the big question is why was there another VA VISN study accomplished in secret and what was the Veterans Administration hiding by not providing that to us until they decided to merge in January? The VISN case study was to clearly identify advantages, disadvantages and opportunities and potential efficiencies. It's just impossible in any way to say that this merger is going to save us money.

A sound business decision based on adding two very large financially deficient entities and concluding that the bottom line results in financial stability is certainly next to impossible to understand. If my law office was millions of dollars in debt, I wouldn't be creating a merger with another law office that was worse off than mine, let alone being located several hundred miles away from each other and expecting to receive economies of scale, and satisfied customers by sending them to Minnesota.

So what is really being accomplished? It appears that the VA is trying to drive veterans away so they will seek other health care providers and use their Medicare benefits instead. Is that why our veteran patients are being told if they want VA to pay for their cardiac care, then it will be accomplished at the VA in Minneapolis not Bryan LGH in Lincoln? They are told if you want to go to Bryan, you will need to use your Medicare benefits. I have sort of a conflict of interest in that we represent Bryan Hospital in Lincoln and Bryan does provide inpatient care for some of our veterans. But we have stories about the VA coming into their rooms, closing the door and saying, "If you want care, you're going to have to go to Omaha. We are going to stop paying for your care at the hospital—at Bryan Hospital," and there are many of those stories.

It appears that the VA is trying to close down veterans' care in Nebraska because the VA has not given this VISN a director with the vision and power and the resources to improve care for all Nebraska veterans.

It appears that the VA is trying to close the Lincoln facility by downsizing, by sending veterans away, by requiring travel and delays in care, and making care for veterans unpleasant or discouraging them with the transfer of the administrative power to Minneapolis.

The VA has reduced care for Nebraska veterans by eliminating certain types of care in Lincoln and Grand Island.

It appears that the VA has reduced care for Nebraska veterans due to reduction of staff, which is going on in Lincoln at the present time, and the loss of doctors and staff because of the underlying fear that they have of closure of the medical facilities. It appears further that the Nebraska veterans health care continues to be the target for new ideas that increases the deficit rather than decreases the deficit. VA administration approved the contracting out of all inpatient care in Lincoln and Grand Island. VA studies show that it is cost prohibitive to do that. But now the VA administration has made a decision to merge without evidence that favorably supports that decision. The first initiative has been extremely costly to Nebraska veterans. The second initiative is resulting in rationed health care.

So in summary, before my yellow light even goes on, the veterans of Nebraska have the right to receive the same health care benefits that are provided to veterans that live in other parts of the country, and that's not so, at the present time at least. Veterans should not have to worry if the VA can afford to treat them. The men and women who were wounded and served our country in the armed forces have earned and paid in full for the medical care that should be made available. I want to thank you very much for allowing me to speak. I appreciate the opportunity and I am finished.

[The prepared statement of Mr. Cada follows:]

PREPARED STATEMENT OF JIM CADA, STATE COMMANDER, MILITARY ORDER OF THE PURPLE HEART, NEBRASKA DEPARTMENT, LINCOLN, NE

In January I presented a letter to Secretary Principi, the Nebraska congressional delegation and other members of the Senate Committee on Veterans' Affairs, a copy of that letter has been provided. The information in that letter continues to be correct, and the questions asked therein are still unanswered.

As the State Commander of the Military Order of the Purple Heart, I am here today as a Veteran that is deeply concerned for the care of all veterans. The battle might appear to have been won, but the war will not be over until such time that the smoke screens or "Veterans" are gone.

During the late nineties questions were raised by both the congressional delegation and service organizations as to why VISN 14 was being considered for a merger. The answer given and received was that "VISN 14 is to small to support its self". A substantial amount of money was spent on various outside consultants that were tasked to study, analyze and provide a written report on the feasibility of merging V14 with another VISN. Feedback on all accounts was that there was "NO Benefit" to both the patient and the financial situation.

The big question is why was there another review "VHA Business Study", accomplished in secret? What was the Veterans Administration trying to hide? By the time the veteran and their constituents caught wind of the internal review and tried to make their voices heard, the ink was already dry on the merger papers.

Lets get down to some hard facts. The smoke has cleared the screen, the merger has happened but the veterans want some answers. I won't bore you with the details of the fifty four-page Business Study. The Business Case Study was to clearly identify advantages, disadvantages, and estimated cost savings, clinical opportunities and potential efficiencies. It is ridiculous for anyone to say that this merger is going to save us money? The only tangible dollar savings even mentioned within the document is or was the "possible savings associated with joining the two Network Offices". A million dollars is nothing when you are facing a $140 million shortfall tins year alone.

Besides you couldn't even count the VISN 14 Network Director's salary since that position was temporary and had been vacant for 19 months. That savings had already been realized in VISN 14.

Why didn't we just do away with facility Directors and save twice the money? If VISN 14 was so small why not treat it like one facility and reduce the number of top management officials, i.e. facility directors, facility chief operation officers, facility associate directors, etc.

A sound business decision based on adding two very large financially deficient entities and concluding that the bottom line results in financial stability is certainly next to impossible to understand. Give me a break! If my Law office was millions of dollars in debt I sure wouldn't be creating a merger with several other law offices that were worse off than mine, let alone being located several hundred of miles away from each other and expecting to receive economies of scale, and satisfied customer by sending them to Minnesota.

What is VA really doing?

(1) It appears that the VA is trying to drive Veterans away so they will seek other health care providers, and use their Medicare benefits instead. Is that why our Veteran Patients are being told if they want VA to pay for their cardiac care than it will be accomplished at VA Mpls not Bryan LOH? They are told that if you want to go to Bryan you will need to use your Medicare Benefits.

(2) It appears that the VA is trying to close down veteran's care in Nebraska, because the VA has not given this VISN a director with the vision and power to improve care for all Nebraska veterans.

(3) It appears that the VA is trying to close the Lincoln facility, by downsizing, by sending veteran's away, requiring travel and delays in care, making care for veterans unpleasant or discouraging them with the transfer of the administrative power to Minneapolis.

(4) The VA has reduced care for Nebraska's veterans by eliminating certain types of care in Lincoln and Grand Island.

(5) It appears that the VA has reduced cue for Nebraska's veterans due to reduction of staff, and the lose of doctors and staff because of the underlying fear of closure of the medical facilities.

(6) It appears that Nebraska veterans healthcare continues to be the target for new ideas that increases the deficit rather than decreases the deficit. VA administration approved contracting out of all inpatient care both in Lincoln and Grand Island. VA studies show that it is cost prohibitive to do that. Now VA administration has made a decision to merge without evidence that favorably supports such a decision. The first initiative has been extremely costly to Nebraska VA Healthcare Resources. The second initiative (merger) is resulting in rationed healthcare.

In Summary, the veterans of Nebraska have the right to receive the same health care benefits that are provided to veterans that live in other parts of the country. Veterans should not have to worry if the VA can afford to treat them. The men and women who were wounded or that served out of the country in the Armed Forces have earned and paid in full for medical care that should be made easily available.

Senator NELSON. Thank you.

Dr. Potter.

STATEMENT OF JANE F. POTTER, M.D., HARRIS PROFESSOR OF GERIATRIC MEDICINE, CHIEF, SECTION OF GERIATRICS AND GERONTOLOGY, DEPARTMENT OF INTERNAL MEDICINE, UNIVERSITY OF NEBRASKA MEDICAL CENTER, OMAHA, NE

Dr. POTTER. Yes. I would like to thank Secretary Principi for his visit and also thank Senator Nelson for the opportunity to speak. I need to say that missing from my credentials is 20 years of very proud service as a member of the medical staff at the Omaha Veterans Administration Hospital where I also led the section of geriatrics within medical service for 6 years.

In 1982 I came to Nebraska as the first geriatrition in Nebraska. And Senator Nelson, I think it's very important that we all appreciate how important the Veterans Health Administration has been in leading efforts nationally to improve the care for our aging population.

The VA's focus on aging veterans, on increasing knowledge of aging, on transmitting that knowledge to health care providers and ultimately improving the quality of care for the aged has been unparalleled nationally.

VA set up as a cornerstone for their programs in aging back in the 1970's, programs known as geriatric research education and clinical centers. Public Law 99–166 expressed Congress intent that there would be a geographic dispersion of the GRECC programs across the United States. There would be 25 of these geographically dispersed. Every network was to have a GRECC, and prior to the merger of VISN 13 and 14, Nebraska/Iowa was one of three such VISN's nationally without a GRECC. This Congress also had recommended appropriations for an additional two of these geriatric research education clinical centers in the current congressional budget. We have been aware of this program over many years and have planned and built out programs and services specifically waiting the opportunity to apply.

I am here representing the researchers, the clinicians and educators in our network. Our specific request is that the Secretary allow this region to compete for a GRECC as would have occurred prior to the merger.

Every GRECC not only serves its region, but it also serves VA nationally. The VA region in Nebraska I would say in particular is well equipped to address two important VA needs. That includes, not surprisingly given the conversations this morning, the needs of rural veterans.

Currently there is no geriatric research and education clinical centers in the country specifically addressing the needs of rural veterans. And second, the Omaha VA Medical Center and the national VA appreciates the importance of aging and alcohol and substance abuse problems. The Omaha VA Medical Center has 1 of 2 VA funded alcohol research centers which would nicely combine with a GRECC in research education and clinical programs to address the problem of aging and alcohol use within VA.

And then in closing, it is my request that our network, the Nebraska-Iowa region, be allowed to compete for a geriatric research education clinical center so that the veterans in the Nebraska-Iowa region don't become the only geographic region in the country without one of these very important valuable and laudable VA resources. And I thank you for the opportunity to be heard.

[The prepared statement of Dr. Potter follows:]

PREPARED STATEMENT OF JANE F. POTTER, M.D., HARRIS PROFESSOR OF GERIATRIC MEDICINE, CHIEF, SECTION OF GERIATRICS AND GERONTOLOGY, DEPARTMENT OF INTERNAL MEDICINE, UNIVERSITY OF NEBRASKA MEDICAL CENTER, OMAHA, NE

GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTER (GRECC)

Summary

During the next 30 years, growth in the older population will transform our society. Caring for a large and growing older population is a national challenge that is more complex when the target population resides in rural setting. The country's largest health care delivery system, the Veterans Health Administration (VRA) has long led efforts to meet these challenges.

The University of Nebraska Medical Center (UNMC) requests funding for a VRA Geriatric Research Education and Clinical Center (GRECC) at the Omaha Veterans Affairs (VA) Medical Center. A GRECC program would provide support for 12 full-time employee equivalents at roughly $1 million annually. This core support would be used to:

(1) develop unique research programs on rural aging veterans and on alcohol use disorders in aging veterans

(2) educate health providers in practice and those still in training on care of the aged

(3) provide innovative clinical care and services to benefit both rural and urban aging veterans.

Need

Between the year 2010 when the first baby boomers turn 65 years of age and 2030, the population over the age of 65 years will more than double. The greatest growth will be among persons aged 85 and older. Nebraska and Iowa already lead the nation in the proportion of the population over 85 years. This mid-western region is additionally challenged to serve an aging population that is dispersed in rural and thinly populated frontier areas. As is true elsewhere, there are far fewer health professionals trained than are needed to serve the burgeoning older population.

The Veterans Health Administration in 1970 initiated a strategy to focus attention on the aging veteran, increase basic knowledge of aging, transmit that knowledge to health care providers and improve the quality of care to the aged. The Geriatric Research Education and Clinical Center (GRECC) program is the cornerstone of this strategy. Public Law 99–166 expanded this program with the intent of establishing 25 of these centers geographically dispersed across the US. Every network was to have a GRECC program. Prior to the merger of the Nebraska/Iowa Veterans Service Network with the Minnesota/North and South Dakota Network in January 2002, Nebraska/Iowa was one of 3 Veterans Networks nationally without a GRECC program. Congressional approval of 2 more GRECCs in the 2002 budget should have allowed UNMC and the Omaha VA to compete for this program with the two other unfunded networks. With the merger, our ability to compete for this program will be lost unless the criteria are changed to allow us to file an application. Moreover, the merger of two rural networks has not reduced the important regional need for a GRECC program to serve our aging rural veteran population or the intent of Congress to place these programs in geographically dispersed regions.

Requested action

Response to the GRECC application submitted an behalf of UNMC/OVAMC to serve the veterans of Nebraska and Iowa region by the provision of:

12 full time employee equivalents, approximately $1 million annually.

Designation as a GRECC also allows: competitive application for ongoing research awards in aging and geriatrics; request for training stipends in medicine, nursing, pharmacy and allied health; and application for continuing education funds.

Institutional uniqueness

The Omaha Veterans Affairs Medical Center is a leader in the conduct of research, education, and tertiary care for veterans in this region. Roughly 630 medical trainees study at the Omaha VA each year for nearly 27,000 hours annually. Since 1991, the Omaha VA and its affiliated program in geriatric medicine from UNMC have laid the ground work for a GRECC through health professional education, outpatient and inpatient services, quality improvement projects and through education, research and training at the affiliated state veterans' home. Throughout these activities service to rural veterans has been emphasized.

- UNMC has a federally funded Rural Research Center that has a major interest in service delivery to older people. No VA GRECC has a program addressing rural veterans.
- The Omaha VA has one of three Alcohol Research Center's in the VA system. Alcohol related disorders are an important problem in older veterans and one that has not been addressed at any VA GRECC program.
- The Omaha VA is in a unique position to address alcohol use problems and rural veterans under a GRECC.

The UNMC Section of Geriatrics has been a regional leader in education and training for the last 20 years.

- Gerontology and geriatric medicine has been taught as part of the curriculum for medical students at UNMC since 1981. Training in geriatrics has been mandatory for Internal Medicine residents and Family Practice residents since 1985 and 1987, respectively.
- Since 1993, the Omaha VA has served as the primary geriatric-training site for residents of Internal Medicine from Creighton University.
- In 1986 UNMC initiated the first (and still the state's only) advanced training program in geriatric medicine for physicians, a program which also employs the Omaha VA as a training site.
- In 2000 the UNMC College of Medicine was one of 20 U.S. medical schools to receive support from the American Association of Medical Colleges to develop model programs for geriatrics education in medical schools.

• In April 2001, the College received a $2 million grant from the Reynold's Foundation to increase enthusiasm among medical students for care of the aged and to provide training within each year of primary care residency training in programs across the state and within the surgical specialties.
• In 2002, the UNMC will complete plans for a geriatric center located between UNMC and the VA. This facility will house the UNMC education, research and clinical, and community outreach program in close proximity to the proposed GRECC.

A GRECC program at the Omaha VA would focus on two unique research areas. health services research for rural veterans and on research on aging and alcohol use disorders. The Omaha VA has a strong geriatrics program and is affiliated with a nationally recognized program in geriatrics at UNMC, making our application for a GRECC unique in the region.

Conclusion

The Omaha VA serves an essential role in health professions education for this region and in the health care of its aging population. Under a GRECC program, the Omaha VA Medical Center in partnership with UNMC is uniquely qualified and prepared to raise the standard of care for both rural and urban veterans, conduct unique research an two important problems of aging, and serve as a regional resource in geriatric education. Resources under a GRECC program would provide annual support of one million dollars to meet the challenge of caring for our aging veteran population.

Senator NELSON. Thank you very much, Dr. Potter.

Mr. Secretary, do you have any questions you would like to ask of any of the panelists?

Secretary PRINCIPI. No, not at this time, Mr. Chairman.

Senator NELSON. Thank you very much for your presentations. I appreciate your being here. Thank you.

As the next panel is arriving, I would like to introduce them. First of all, we have Greg Kulm, Chapter 260 Officer, Military Order of the Purple Heart, Nebraska Chapter; Jerry Bove, the Nebraska Department Commander, The American Legion; Alfonso G. Martinez, Jr., Nebraska State Council President, the Membership Chair of the Vietnam Veterans of America; Howard Braman, the Commander of the Nebraska Disabled American Veterans; and Craig Enenbach, Treasurer and Member, Board of Directors, Great Plains Chapter of the Paralyzed Veterans of America.

Howard, you drew the long straw.

STATEMENT OF HOWARD BRAMAN, COMMANDER, DISABLED AMERICAN VETERANS

Mr. BRAMAN. Yes, sir, it sure looks that way, sir.

Mr. Nelson and Mr. Principi. My name is Howard Braman. I'm the Commander of the Disabled American Veterans Department in Nebraska. I'm a retired 26-year-plus military man, 70 percent disabled. I am here because I'm kind of upset the way VISN 13 and 14 was combined. I would like to know why the veterans were not notified in the two districts. I would like to know why the people had to travel so far from one element to another element to another element. I would also like to know why the moneys are lost between the two elements, VISN 13 and 14, and why we cannot have more CBOC's.

We had two elements out west, one is in North Platte across a CBOC. It's a regional hospital, bigger than any hospital here in Omaha. We have another one in Scottsbluff, the same way, and yet again, we send people from Scottsbluff all the way up to Hot Springs and Cheyenne.

Why can't we send them across the street in Scottsbluff and North Platte? And why do we have to send people from North Platte to Omaha when we have three—as you said, two hospitals between here and there and they're not being used, and yet, again, they want to take and combine 13 and 14 into one humongous VISN. I don't understand that, and I want you to explain to me why this was done so that I will be able to understand it and let the Disabled American Veterans, Department of Nebraska, know why you did this. So please explain to me why.

Senator NELSON. If we could go forward then, we will take notice of that.

Mr. BRAMAN. I'm done.

Senator NELSON. Thank you, now Al.

STATEMENT OF AL MARTINEZ, STATE PRESIDENT, VIETNAM VETERANS OF AMERICA AND LEGISLATIVE COORDINATOR

Mr. MARTINEZ. Yes. My name is Al Martinez. I'm State President of Vietnam Veterans of America and Legislative Coordinator for the State as well.

Honorable dignitaries and distinguished fellow colleagues, comrades, ladies and gentlemen. Our concern that the 200,000 veterans in our VISN that use the VAMC is—even through at great lengths of cutting budgets, employee reduction, readjusting staff and increasing the number of veterans that use the VA health care system, we were merged with a larger VISN that is also failing according to the VA data and reports. How can two wrongs make a right? Because they are larger, we are not merged, we are absorbed. This is bad enough that we will be competing for moneys funding on a lager scale and that Nebraska and Western Iowa on the lower scale half would make things and matters worse.

We will now compete among the VAMC's in our area for survival. It has been proved more than once time and time again that the problem was not with the employees, staff or veteran patients, but rather the upper administrative task force employed by the VA and health care system. Do not chastise our VAMC employees and patients for the lack of competence in the upper administrative and operating system that have caused the VA to lose money in care of funding by the Federal Government.

Not long ago our VISN Director Vincent Ing was transferred to us in Nebraska to help us and it turned out that he brought problems from previous VISN's and when it was all said and done, we lost Vincent because of the inadequacies and problems that came with him. Now you bring us a new VISN person, Mr. Petzel, and we don't know him as well, but our concern is that this is not a failing VISN coming to help another failing VISN and that the veterans will not be taken in at the expense of inadequacy of administration and policy of administration in care of the infrastructure.

We now have a better understanding of the 44 classifications of veteran patients. I believe they might have even added a few more. But they are only three forms of amounts of VERA reimbursement, approximately $105, $2,800, and $3,200 per patient. Over the previous past years our VISN lost moneys in over 50,000 patients to a negative because of the lack of oversight administratively. Since then, over 20-plus employees were resigned, terminated, or trans-

ferred. This is only one level and everything goes wrong at the highest management level. Staff and employees take the pressure, but higher level positions are transferred and become someone else's problem. This needs to be addressed.

Already the Omaha VAMC is overwhelmed with parking space from priority veterans. A smaller staff and employees are serving a greater number of increase in veteran patients. Even though a greater number of veterans are using the VA health care, VAMC's are competing in our area to stay open. Once again, this kind of stress on employees and staff at the expense of saving a dollar and jeopardizing health care for the veteran is not acceptable. Furthermore, transferring and rearranging upper level management to cover mistakes at the expense of the VA is not helping our cause.

Just recently President Bush approved $107 million and added $400 million to our emergency funding for the VA health care system. This should not be about asking for a loan or a handout. This should be about capitalizing on the hard work and effort that VISN 14 originally made and continues to make for a better present, future of our VAMC's. Therefore, if our VISN 14 was merged by VISN 13, absorbed to make 23, make sure we are not dissolved in the process and when moneys funding is allocated on a priority basis, we in Nebraska and Western Iowa find ourself at the bottom of this number scale.

My time is out and I have a few more things to read, but the only thing I will ask you is this: With the merger of 13 and 14, what are the benefits the VA and veterans of both VISN's who are in will lose or win? With the shortfalls of VERA funding, what efforts will this have on the merger of 13 and 14? Where do we stand on an opening at—admitting centers of excellence for Hepatitis C and where will the closest one be to us? How do you account for the VISN directors and the hospital directors who fall with a golden parachute and can't be touched? Should they be held more accountable? What are the long-term plans to improve the VA system and to back up the shortfall of moneys that we have lost in the past?

Thank you.

[The prepared statement of Mr. Martinez follows:]

PREPARED STATEMENT OF AL MARTINEZ, STATE PRESIDENT, VIETNAM VETERANS OF AMERICA AND LEGISLATIVE COORDINATOR

Our concern, the 200,000 Veterans of our VISN 14 that use the VAMC system, is that even though VISN 14 went through great lengths of cutting budgets, employees, readjusting staff and increasing the number of Veterans that use the VAMC Healthcare; we were merged with a larger VISN 13 that is also failing according to V.A. data and reports. How can two wrongs make a right? Because they are larger, we were not merged—we were absorbed. It is bad enough that we will be competing for monies funding on a larger scale with Nebraska and Western Iowa on the lower half, but, to make things/matters worse, we will now compete among the VAMC's in our area for survival. It has been proven more than once, time and time again, that the problem was not with the employees, staff or Veteran patient, but rather the upper administrative task force employed by the V.A. Healthcare System. Do not chastise our VAMC employees and patients for lack of competence in upper administrative operations that have caused the V.A. to loose money c/o funding by federal government. Not too long ago our VISN Director Vincent Ing was transfered to us in Nebraska to help us and it turned out he brought his problems with him from his previous VISN. Now you bring us Mr. Robert A. Petzel from another failing VISN to help us again? Not all Veterans are highly educated especially in the areas of the V.A., but they see what is happening to their healthcare system.

Examples:

1. We now have a better understanding of the 44 classifications of Veteran Patients, I believe they might have even added a few more. But there are only 3 forms (amounts) of VERA Reimbursement—approximately $105.00/patient, $2,800.00/patient, or $3,200.00/patient. Over the previous/past years our V.A. system lost monies on over 50,000 patients to the negative because of this lack of oversight administratively. Since then over 20+ employees were resigned, terminated or transferred. This is only on one level. Everytime something goes wrong on a higher management level, staff and employees take the pressure. But higher level positions are transferred and become someone else's problem. This needs to be addressed.

2. Already the Omaha VAMC is being overwhelmed with parking space for priority Veterans. A smaller staff and employees are serving a greater number/increase in Veteran patients. Even though a greater number of Veterans are using the V.A. Healthcare. VAMC's are competing in our area to stay open. Once again, this kind of stress on employees and staff at the expense of saving a dollar and jeopardizing healthcare for the Veteran is not acceptable. Further more, transferring and rearranging upper level management to cover mistakes at the expense of the V.A. is not helping our cause to stay open and functional. As for priority 7 affecting the budget at this time 1–3 become service connected changing their state.

3. Just recently the President of the U.S. Honorable Bush approved $107 million with and added $400 million c/o our Emergency Funding for the V.A. Healthcare System. This should not be about asking for a loan or a handout. This should be about capitalizing on the hard work and effort that VISN 14 originally made and continues to make for a better present and future of our VAMC's. Therefore, if our VISN 14 was merged by VISN 13 / absorbed to make VISN 23. Make sure we are not dissolved in the process when monies/funding are allocated on a priority basis and we in Nebraska and Western Iowa find ourselves at the bottom of the numbers scale.

4. Satellite clinics were established in Norfolk, Nebraska and other areas to save on transportation and facilitate service to Veterans in rural areas. This is great up to the point when funding allows for 200+ and the needs are 300+ as an example. Enrollment and the bulk of services and special clinics remain at the Omaha VAMC which is fine as long as the increase of services and patients is equal by funding, staff and employees to provide these services. Quality of LPN's, RN's, PA's, and specialized staff/personnel should also be maintained and monitored based on their qualifications and not on the work-overload.

5. Recently areas of special need were addressed. Example: Pharmacy—The question extra personnel needed to evaluate the issue of overmedications was brought up and keeping up with waiting time for medications. This is fine as long as time and money is not shifted and over concentrated/spent on higher paid (evaluations) employees/staff to supervise and less effort on actual pharmacy service and time element/waiting for medications to be dispensed to Veterans.

6. When Veterans are transported from one end of the state to another, without informing them of doctor cancellations, this is burned to the Veteran especially if Veteran is told he will be seen later that day and later told to come back the next day and no provisions are made to cover the cost of overnight lodging for that Veteran.

7. Numbers of Veterans using the V.A. will continue to grow/increase based on older Veterans, Millennium Bill and approved service connected disabilities long over due c/o radiation; Agent Orange; P.T.S.D.; diabetes; heart, lung and cancer medical problems; Persian Gulf Syndrome and more. But they (V.A.) will not meet the needs of these Veterans if the VAMC's are not allowed to maintain the needed funding budget to continue services so that Veterans can continue to come back and want to come back. Keep in mind that our V.A. Healthcare System has not only improved nation wide in comparison, quote, to the private sector. But is actually a very important factor in the future of this country/nation regarding Biological/Chemical Hazards c/o treatment, P.T.S.D. c/o terrorism of victims, the Security of the Land Plan should include the knowledge and experience the V.A. has not the private sector in dealing with combat and biochemical hazards of war. If anything, the more you invest in our V.A. Healthcare System now the better you secure and insure the needs of our future Veterans and Citizens of this country/nation.

8. Regarding questions and answers about the VISN merger, I have attached the VISN's response and will write my response.

Question A. Why the study was done?

VISN Answer. There in fact is an increase in Veterans using the V.A. not because of the declining Veteran population but rather more Veterans using the V.A. due to age, loss of civilian healthcare due to income, increased eligibility of benefits c/o service connection and the Millennium Bill.

My Answer. VA is constantly looking for ways to improve services for veterans and to expand programs to more veterans. Moreover, VISNs 13 and 14 have small, declining veteran populations as well as overlapping populations in several areas. By merging the management teams at the VISN levels, VA can continue to serve veterans with quality medical care while reducing overhead cost, and combining their strengths to form what we expect wilt be an exceptional network. Essentially, the consolidation at the management level should be transparent to the veteran.

Question B. How much money will be saved?

VISN Answer. Prior to the merger, money was saved due to a reduction in V.A. spending and employees being reduced to a smaller staff. A better understanding of the VERA Program c/o Veteran classification as patient vs. reimbursement. Unfortunately, our farmers were penalized in eligibility of benefits.

My Answer. The goal of the merger is not to save money, but to redirect resources toward patient care. How much will be redirected to more patient care is unknown.

Question C. Why aren't other VISN's merging?

VISN Answer. We are not unique, unless it is because we are the smallest, or the easiest one to work with and use for an example to the rest.

My Answer. The VISN 13–14 merger is unique due to the characteristics and geographic proximity of the two networks. No other mergers are under consideration at this time.

Question D. How many employees will be affected by this?

VISN Answer. That is not the question. The question is how many more now and how many more in the future.

My Answer. Only a small number of employees at the VISN level will be immediately affected at the time of the merger. The exact number of employees is yet to be determined. We will make every effort to find continued employment for affected employees within VA.

Question E. How will the merger be managed?

VISN Answer. The Integration Advisory Committee Team is composed of 10 to 15 people who have survived being transformed, resigned and retired. They will now be led by a new VISN Director who comes from a failed VISN. What is wrong with this picture?

My Answer. A joint, VISN 13–14 Integration Advisory Committee will be formed to develop the plan. This will be a team of 10 to 15 people.

Question F. Will services at some locations be closed or consolidated at other locations?

VISN Answer. This question should not be a question. Especially since steps are already being taken to do the above and since employees already feel the need to compete or risk being closed.

My Answer. No facilities are scheduled to be closed under this merger.

Question G. What will the new network be called?

VISN Answer. VISN 23 c/o 22 VISN'S.

My Answer. VISN 23.

Question H. Office to be located and consolidated?

VISN Answer. Originally in Lincoln, that has now changed.

My Answer. That will be decided by the Joint advisory committee.

I am only one (1) of 200,000 Veterans that will be affected.

Hopefully this will give you some ideas of my/our concerns. I have more documentation and data I will have at the hearing.

Senator NELSON. Thank you, Al.

Jerry.

STATEMENT OF JERRY P. BOVE, STATE COMMANDER, THE AMERICAN LEGION, DEPARTMENT OF NEBRASKA

Mr. BOVE. Secretary, Mr. Congressman.

My name is Jerry Bove. I'm a State Commander for the Department of Nebraska, American Legion. I've got about 55,000 people that call me occasionally. I'm here today representing not only to bring forth some of their concerns, but my own experiences as the veterans across the State do call. First of all, I will discuss my personal experiences.

I must say at this time that prior to the merger of VISN 13 and 14, I was well satisfied with the service and treatment that I re-

ceived from the VA medical facilities. Since 1986 I have had 10 surgeries in Minneapolis, Lincoln, and Sioux Falls. I'm a 100-percent disabled veteran that was taken care of. I have had various procedures including physical therapy at non-VA facilities and payment to these facilities was no problem until now.

I'm receiving a bill from a non-VA facility for services in September 2001. I contacted Des Moines and their comment was, well, it wasn't preapproved, we are going to deny it. When the letter gets there, appeal it. We will have the board look at it and probably approve it since you are service-connected. The problem is that it is already too old and interest is multiplying. One problem seems to be that county veterans service officers don't call in in a timely manner and they say it's not preapproved. I think this is part of the county veterans service officers' job, but when I asked Des Moines about it, they said, well, they don't work for us and it's your responsibility. If I'm in an ambulance going to a hospital, am I supposed to say wait a minute, am I supposed to call Des Moines and get this thing approved before you can drop me off?

Appointments are being canceled and rescheduled regularly. According to the VA medical center, this is due to a personnel problem. I call the hospital about rescheduling an appointment with my primary care doctor and was told October would be the earliest that I could get in. Six months seems to be a bit too much here.

I spent some time years ago working on combining appointments as I live 250 miles from a hospital. It was working until the changes. They want me to drive over 500 miles for a 10-minute chat for the doctor. I get paid mileage, I spend over 8 hours driving. It doesn't make a lot of sense to me.

It seems as though the doctors are on kind of a part-time schedule, although clinics are scheduled every day. It's a different one every day, so you can't combine your appointments to 1 day. They want you there all week.

Now, it might be my imagination, but things seem to have gone awry after the integration. Do we blame the problem on the merger or do we blame the hospital administration? Some of these problems are not hospital related.

The current administration budget calls for the Category 7 veterans already in the system to pay the first part—to pay part of the first $1,500 of their annual health care. Now, as I understand, this has been dropped now. They want to drop the Category 7 veterans. Well, that got shot down. They did raise the co-payment on their drugs $2 to $7 per prescription. Now, I understand if they drop Category 7 this year, do you look at 6 the next year as a cost-seeking matter? It doesn't really make sense to me, but——

Many veterans are receiving inaccurate insurance and co-payment bills from the VA. Now, this is an administrative problem. The VA is not making timely payments, nor are they submitting insurance claim forms in a timely manner.

As Commander of the American Legion, I have received letters from veterans about their problems. I received a letter from a lady veteran who was treated, but the bill took so long to get to her, her insurance refused to pay it because it was not submitted in a timely manner. In other words, it didn't make the 6-month cutoff. One of the first questions asked of you when you check in at the VA

is do you have insurance. They then forget to send the bill to the insurance company. Nine, 12 months is not unusual now. And when the insurance company refuses to pay, who gets stuck? The veteran.

Another veteran was in an ambulance. He was taken to a non-VA facility. He needed immediate help. And he's a 40-percent service-connected veteran, but he was told that treatment was not preapproved, the bill was his responsibility and he cannot afford it.

Now, I understand there are rules and regulations and hospital administrators have their problems. VISN 23 has its problems, but who loses through all of it? It's the veteran. Now, I understand there are veterans in Florida who wait up to 3 years to see a doctor, so maybe we are the lucky ones.

Thank you for the opportunity to speak. I appreciate it. Thank you.

Senator NELSON. Thank you, Jerry.

Greg.

STATEMENT OF GREG KULM, ON BEHALF OF THE MILITARY ORDER OF THE PURPLE HEART

Mr. KULM. OK. Senator Nelson, Secretary Principi. My name is Greg Kulm and I'm here representing the Military Order of the Purple Heart. I would like to thank you for allowing me the opportunity to voice my concerns and personal opinions regarding the veterans of this region as well as the rest of the country. While serving with the U.S. Marine Corps at the age of 18 in Vietnam as a rifleman, I was severely near fatally wounded while patrolling in an area that was filled with land mines. I lost both my legs and suffered multiple complications while being cared for immediately after my injury occurred. I have been coming to the same VA medical facility since 1970, over 32 years, for all the medical complications I have incurred because of my injuries in Vietnam.

Regarding the merger of VISN's 13 and 14 to one VISN, my first concern is how does it affect the veterans seeking medical care. This is a management change. You are taking two regions—correction—VISN's that are currently underfunded and combining them into one larger VISN that will nearly be under—that will be underfunded. The veterans seeking care at the medical facility will not see any difference in the daily operation and care with this merger. Will there be an increase in budget in combining these VISN's? There's only two ways to solve the problem, increase the funding for the hospitals, cut back on the patient load by turning certain veterans away.

In the last few years I have personally seen and have been affected myself by the deteriorating care for the veterans at the Omaha VA Medical Center. It's not the VA employees, it's the overbooked schedules and the lack of staff that provides the care in a proper and timely manner. I know the solution and I think that Washington knows the solution. It's money. And it's my opinion that the current politicians don't want to appropriate funding for adequate medical care that the veterans so deserve, why give funding to people who will not be around in 5 to 10 years to vote for them.

Is it who you know in Washington because it just took 1 year to get $17 million for Nebraska to build a foot bridge over the Missouri River? Just how many people are going to walk over the river from Omaha to Council Bluffs? Think of how much medical care that amount of money would have provided to the veterans of the VA medical center.

I ask you, have the politicians lost sight of where their priorities should be? Holding hearings, setting up committees and changing management is a waste of time. All of these things do nothing to assist the veterans with their medical care. It just delays it until the problem disappears.

Thank you.

Senator NELSON. Thank you.

Craig.

STATEMENT OF CRAIG F. ENENBACH, NATIONAL DIRECTOR, GREAT PLAINS PARALYZED VETERANS OF AMERICA

Mr. ENENBACH. Senator Nelson, Secretary Principi and staff and others responsible for conducting this hearing, I want to thank you on behalf of the members of the Great Plains Paralyzed Veterans of America. The merger of VISN's 13 and 14 into a new VISN 23 represents a major reorganization of the Department of Veterans Affairs Health Care Delivery System for the upper midwest and the Great Plains of Iowa and Nebraska. The merger also affords the VA with opportunities for efficiencies and improved services to veterans. However, for veterans with spinal cord injuries, several issues must be addressed.

PVA members and all veterans with SCI rely upon the VA for a lifetime of health care ranging from acute care, immediate postinjury care, through rehabilitation, sustaining care and finally, Various options for long-term care. VA and Congress have over the years clearly recognized the need for this full continuum of care and have created the VA's unique spinal cord injury system. This system is a nationwide system with centralized guidance and not constrained by VISN alignments. This is clearly evidenced by the fact that neither VISN 13 nor VISN 14 has a spinal cord injury center and veterans with spinal cord injury residing here must travel significant distances for their care.

Many of the members of Great Plains PVA travel to Milwaukee, St. Louis, and even Seattle for their care at a VA spinal cord injury center. In fact, as we speak, one of our members is recovering from surgery in Milwaukee. This care has been augmented by the creation of a hub-and-spoke feeder system that relies upon specialty teams of clinicians who serve as primary care providers directing veterans with spinal cord injury to VA spinal cord centers when medically appropriate and necessary. This system must be maintained with the merger and the overall provision of care for veterans with SCI must be assessed in an effort to more clearly facilitate access and decrease travel times.

The Minneapolis VAMC has evolved into an exceptional source of care for many veterans with SCI and its elevation to a fully recognized VA spinal cord center is strongly supported by PVA. A center in Minneapolis will greatly enhance the availability of SCI care in the new VISN 23 by significantly reducing travel distances. PVA

has analyzed current patient demographics and SCI center utilization and has determined that the creation of a center in Minneapolis can be achieved without the patient base of other centers being eroded. This center must, however, be established and operated consistent with VA policy and guidance currently established in VA Handbook 1176.

Finally, Senator Nelson, I would be remiss if I did not point out that regardless of efficiencies and opportunities created by the merger of 13 and 14, this area and all of the VA needs more money if it is going to continue to meet the needs of enrolled veterans in a timely and appropriate manner. PVA is a coauthor of the Independent Budget with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, and this year we are calling upon the administration and Congress to adequately fund VA. A supplemental appropriation is currently being considered by Congress for this current year, fiscal year 2002, and it is our firm belief that VA needs at least $400 million to meet its present obligations. We also believe that an increase of $3.1 billion over next year's level is necessary to fund VA health care for fiscal year 2003.

Thank you for this opportunity to present the views of Great Plains PVA and I will try to answer any questions you may have.

Senator NELSON. Thank you very much.

First of all, Mr. Secretary, any questions or comments you would like to make in connection with this panel?

Secretary PRINCIPI. Well, Mr. Chairman, I too appreciate the testimony of the men sitting before me today, and I appreciate their insights and their concerns.

Maybe a general observation. And I don't want to sound defensive—I want to sound positive. There is no nation on Earth, no nation, and I have looked because I was chairman of the Congressional Commission on Service Members and Veterans Transition Assistance a few years ago, known as the Transition Commission, and I was chairman of that Commission, and our congressional commission summoned representatives from all of our allied countries around the globe to Washington to receive testimony from them as to what their countries do for their Nation's veterans, and it was extraordinary how little they do and how much we do. Now, that's not to say that we can ever repay the debt that we owe to any man or woman who serves in uniform or combat, especially someone like Mr. Kulm who lost half of his anatomy in Vietnam. You just cannot repay that debt. There is simply no way to do that. But our Nation is a generous nation. Our President, our Members of Congress are very, very generous to VA.

I happen to lead the second largest department in all of Government, and with this year we'll probably be close to $60 billion in appropriations. Again, is it enough? No. 220,000 employees. No department has that many people other than Defense, and they have a lot more. They're in a class all by themselves. But I just believe, and I don't want to say I disagree, but I just believe that our Nation cares very, very deeply about men and women in uniform. I mean, the fact that more and more veterans are coming to us for care is not an indication the care is lousy, it's an indication that the care is darn good. It is so good, as a matter of fact, that they want to come. Their benefit package is so attractive and, as you

know, many Americans have to spend $300, $400 a month, who are not veterans, to get their prescriptions filled. My mother is one of them. I sent her a check every month for $400 so she could buy her medication. Any veteran in this Nation, whether they are someone like Mr. Kulm who is 100 percent service-connected and paid almost the ultimate price, or someone who is making $50 million a year and never saw combat, doesn't have any disabilities, no military service disabilities are treated equally under the law. No one has a priority for care, and they can get the nonservice-connected wealthy veteran who can come to VA and get his or her drugs for $7 and can be in front of the line. But that's the way the system has evolved, and as a result of it, we have so many more veterans coming to us in places like the Sun Belt and Florida, and we try to do the best we can with the resources we are given. And I'm not going to sit here and say to you that we have all the dollars we need. We don't. I have been very, very honest about it, and I said hard choices have to be made. One is Medicare subvention. If we don't get Medicare subvention, then copayments for those who are nonservice-connected high-rank help to share in the cost of their care. Another is to suspend enrollments for Priority 7 veterans. I came very close to doing that last year because I felt that the quality of health care in VA was being impacted, and veterans are not well served when they have to wait 6 months or a year to get into an outpatient clinic for care. We are not meeting their expectations, and that's not the way we should be conducting ourselves. So I said rather than disenroll anybody, I should suspend enrolling new Priority 7's so those who are enrolled can at least get into the clinic on a timely basis. But fortunately the President and Members of Congress came to my aid, and we have a supplemental pending before Congress, and hopefully that will be approved soon, and we'll be able to continue to keep the doors open to everyone. But those are just some of the dynamics of the challenges we face in providing health care. There are no easy answers. If there were easy answers, they would have been done a long time ago. The easy answer for me is to do nothing, argue for more money and not make the tough decisions that have to be made, but I felt that suspending enrollment was the right decision. Tough politically to do, but I think the right decision.

Consolidating the two networks is an issue. Now, network people are very important people. They're wonderfully dedicated people. They're support people, and you need support people. Just like in the military, we needed support people. You know, you have the folks in the trenches, and you had the folks in the rear echelon providing support. But I want to make sure that our truth-to-detail ratio is balanced as well. That's when I saw we had two networks that were really quite small relative to the others and with veterans, of course, declining not only in Nebraska and Iowa, but everywhere else as well. I felt it made sense to be more efficient, to be more effective, that we can consolidate those support functions into one network rather than hiring a new network director at a relatively high level. But I insist, I insist that the veterans of this area of Nebraska be treated fairly and equitably, and if they're not, then I will take steps to ensure that happens. But I have every reason to believe that under Dr. Petzel's leadership, that will be the

case. The fact that he has been here so many times is ample evidence to me that he cares deeply about the veterans of this area, and he's not going to shortchange them to send the money to Minneapolis. Minneapolis is an important medical center. And if I need open heart surgery, I may want to get on a plane to go to a place like Minneapolis where I know that you've got some superb surgeons there, not that you don't have them in Omaha or other parts of this wonderful State, you do. Obviously I just saw the magnificent hospital down the road, I believe the University of Nebraska. So we do have that here. But the fact is that we've got to make some tough choices gentlemen, and I'm not going to shy away from making them. I mean—I only have one concern at heart and that is veterans. I've got two sons on active duty in the Air Force, one in Southwest Asia, I've got a son who's joining the Marines. I care deeply, very deeply about men and women in uniform who are our Nation's veterans, and I would do nothing at all ever to compromise that concern, and I believe that the people who work for me feel the same way. It's not to say it's easy, but I feel that we're going in the right direction and I feel with support from people like Senator Nelson and the members of this delegation, Chuck Hagel, another great Vietnam veteran, and Mr. Bereuter and Osborne and the rest of this delegation, that you're in good hands. Thank you.

Senator NELSON. Thank you very much, Mr. Secretary. And as we draw to a conclusion, there are a couple of observations I would like to make. First of all, I think that the concern here is that there's a question of whether it's a merger or absorption—to merge or to absorb. Based on what you're telling us and what Dr. Petzel is telling us, is that we're not going to be absorbed in Nebraska and be a subset of Minneapolis administration and management. You'll continue to provide the kinds of services as close to home for our veterans as is entirely possible, recognizing that there are some challenges in a State like Nebraska. We are geographically challenged; a large area and a smaller population. We're not alone in that regard, but we are affected that way.

Also, there is a concern about funding. There's no question that what we must fund these programs in the most appropriate and generous way possible. While recognizing all the needs we have as an American government, challenges with war, but also challenges with needs here at home. You have my full commitment to work with you as a member of the Veterans' Affairs Committee to make sure that we work in every way possible to get adequate funding for our veterans, and particularly as it relates to this area.

I often hear how bad things are, as we all do, because there are challenges here and challenges there. I know we must identify and deal with those challenges as quickly and as appropriately as possible.

I know you have been on Capitol Hill talking to us about the challenges that you have. You're hearing from people right here on the ground, the folks who receive the benefits, about their challenges. I hope we can always continue to work together, as we have, to try to deal with each of the particular situations we find, but to also try to improve overall. We can reduce the number of challenges that we have by better management, but also by the delivery in the quality and quantity of care.

I think today's hearing has been productive. I certainly have learned more. It's important to hear specifics. In Washington, all too often we deal with generalities, but I think it's good for us to be here. We are talking to people who have the availability of those services, who have used them, and who hear from their peers about what their experiences are, otherwise, we're looking at numbers and I'm one who likes to put faces together with numbers every time that I possibly can.

I want to thank you very much for being here with us today for your testimony and also for staying with us to hear panels II and III.

I would also like to thank my staff, particularly Eric Pierce, my staff in DC and the staff here in the Nebraska offices for your help in putting this together, and, of course, the staff from the Veterans' Affairs Committee who are here today making sure that this is, in fact, an appropriate hearing conducted under the auspices of the Senate Veterans' Affairs Committee.

With that, I get to do this again now, [raps gavel] with that, I call the hearing concluded.

[Whereupon, at 12:11 p.m., the committee was adjourned.]